Oak Tree Forest Limited

Ellern Mede Moorgate

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The service did not provide safe care. The wards did not have enough nurses and reliance on agency workers was high. Staff did not always assess or manage risk well and incidents causing harm to people using the service occurred during our inspection. Staff did not minimise the use of restrictive practices and people using the service told us about the negative impact this had on them.
- The service did not provide a full range of treatments suitable to the needs of the patients or in line with national guidance about best practice. We observed care being delivered which did not align with nationally recommended practice for the treatment of eating disorders. People using the service were not receiving adequate psychological therapies to support their recovery. Relatives and stakeholders had raised concerns about some people not progressing during their admission. Due to the staffing pressures and the complex needs of the patients, staff did not have the capacity to adequately engage in clinical audit to evaluate the quality of care they provided.
- Managers did not consistently ensure that staff received adequate training, supervision or appraisal. Staff did not always engage effectively with those outside the ward who would have a role in providing aftercare.
- Staff did not always treat patients with compassion and kindness, respect their privacy and dignity, or understand their individual needs. Staff did not consistently involve patients and their families in care decisions.
- People told us that they felt bored and that there was little to do at the hospital. We did not observe many organised activities taking place during our inspection.
- Admissions and discharges were not always managed well, which resulted in additional pressures on the ward staff.
- Governance processes did not identify some of these significant shortfalls in the care provided at the hospital and staff did not feel well supported by senior managers.

However:

- The ward environments were safe and clean.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- People were receiving meaningful support from the dietetic team.
- Senior managers had started a number of improvement projects including the creation of patient inclusion lead and autism champion posts

Letter from the Interim Chief Inspector of Adult Social Care and Integrated Care, James Bullion:

I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

A final version of this report, which we will publish in due course, will include full information about our regulatory response to the concerns we have described

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Inadequate 	Our rating of this service went down. We rated it as inadequate. See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Ellern Mede Moorgate

Ellern Mede Moorgate is a hospital run by Oak Tree Forest Limited. It provides specialist eating disorder inpatient services for children and young adults. The hospital was registered in September 2019 and provides treatment for up to 12 patients, both male and female. It has two six-bed wards. Inca ward is for young people aged 8 to 18 and Aztec ward is for young adults aged 18 to 25. The hospital offers treatment to patients with complex eating disorders and can support patients who require nasogastric feeding. The hospital has an on-site school to provide patients with an education during their admission. At the time of our inspection, the hospital had a registered manager who was also the nominated Controlled Drugs Accountable Officer (CDAO).

The service is registered by the CQC to provide the following registered activities:

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

• Treatment of disease, disorder or injury.

The service has been inspected three times previously since it opened. The last time was in May 2023 where we carried out a comprehensive inspection. Following this inspection the provider was rated as requires improvement overall with breaches of Regulation 9 (Person-centred care), Regulation 17 (Good governance) and Regulation 18 (Staffing). We did not find that these issues had been resolved during this inspection, including continued staffing concerns, overuse of restrictive practices, lack of access to psychological therapies and concerns relating to the provider's governance and quality monitoring systems.

We undertook this inspection of Ellern Mede Moorgate due to concerns received about the quality of care and the safety and wellbeing of the young people using the service. We carried out an unannounced comprehensive inspection of all key questions.

What people who use the service say

The people we spoke with told us that the hospital was usually clean and tidy, with no significant environmental issues. People told us there was not much to do, with very few activities ever taking place. People said there was often not a lot of staff around and they could go a whole day without speaking to anyone. Some young people also said the night staff were rude to them. The young people we spoke with said they did not always feel safe at the hospital because physical restraint was used a lot and people told us they had been injured during restraints. People raised concerns about the lack of psychological therapies to support their recovery. People told us that they did not feel involved in their care, or their discharge plans and they did not have a copy of their care plan. Carers told us that they felt their relative was safe at the hospital and that the visiting rooms were clean and appropriate for their needs. Some carers told us they did not always feel well informed about or involved in their relative's care. Carers told us that they were able to give feedback about their experience, but they did not always feel assured that improvements would be made if they raised concerns.

How we carried out this inspection

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

During the inspection visit, the inspection team:

Summary of this inspection

- toured the building and looked at the quality of the environment
- observed how staff were caring for children and young people
- spoke with 4 patients and 5 carers
- spoke with the registered manager, the consultant, the clinical services manager and the deputy hospital manager
- spoke with 20 other staff members including doctors, nurses, support workers, allied health professionals and domestic staff
- attended and observed a shift handover meeting and a morning communication meeting
- attended and observed a multidisciplinary meeting and a Care Programme Approach review for 2 patients
- attended and observed community meetings for patients on both wards
- looked at the care records of all 11 patients
- received feedback from the independent mental health advocate for the service, an external specialist pharmacist, representatives of local safeguarding teams for children and adults, 2 specialist segregation practitioners and 3 service commissioners
- reviewed the management of medicines and looked at the prescription charts of 9 patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that there are adequate numbers of suitably qualified, trained and experienced permanent nursing staff to meet the needs of the patients and reduce the number of agency staff so that people receive consistent care from staff who are familiar to them. (Regulation 18 (1) (2) (a))
- The service must have systems in place minimise the risk of staff being injured at work. (Regulation 17 (2) (b))
- The service must ensure that people using the service have regular one to one time with their named nurse. (Regulation 9 (3) (c))
- The service must ensure that all staff who may have to undertake physical interventions as part of their role are trained to use the restraint techniques used at the service before working on the wards. (Regulation 12 (2) (c))
- The service must review the use of restraint and restrictive practices at the hospital, including consultation with patients, relatives and staff, to ensure these are only being used as a last resort, in the best interests of people using the service and in line with people's individual needs and expressed preferences as far as possible. (Regulation 17 (2) (b))
- The service must ensure that all staff responsible for the insertion of nasogastric feeding tubes are trained and signed off as competent to perform this task before doing so. (Regulation 12 (2) (c))
- The service must ensure that risk assessments are reviewed and updated as soon as possible following incidents which indicate a change to the risks relating to the individual's care. (Regulation 12 (2) (a))
- The service must ensure that any risks relating to a period of absence from the hospital are considered prior to the patient leaving the ward and records are kept of this process. (Regulation 12 (2) (a))
- The service must ensure that people are reviewed by a qualified clinician as soon as possible after any head injury and people who need urgent physical healthcare are supported to access this without delay. (Regulation 12 (2) (b))

Summary of this inspection

- The service must ensure the record keeping systems for incidents of physical restraint support staff to accurately document the length of time people are spending being physically restrained (Regulation 17 (2) (c))
- The service ensure that people are not subject to excessive restrictions due to type and quantities of medication they have been prescribed and that national guidance on stopping the over-medication of people with a learning disability, autism or both (STOMP) is being taken into account where relevant. (Regulation 12 (2) (g))
- The service must ensure that when incidents occur and/or complaints are made about the service action is taken to address any lessons learned and improve practice to minimise the risk of a recurrence. (Regulation 17 (2) (a))
- The service must ensure that young people have access to psychological therapies in line with national guidance on eating disorders where this has been assessed as appropriate to support their recovery. (Regulation 9 (3) (b))
- The service must ensure that staff receive regular clinical supervision and performance appraisals. (Regulation 18 (2) (a))
- The service must ensure that the arrangements for non-consensual nasogastric feeding, toileting and bathing support the privacy and dignity of people and avoid unnecessary distress. (Regulation 10 (2) (a))
- The service must ensure that staff treat patients with kindness, respect and compassion and are supported with any wellbeing issues which are leading to compassion fatigue. (Regulation 10 (1))
- The service must ensure that young people and, where appropriate, their families and carers, are involved in their care to the greatest extent possible and that attempts to involve people in their care are documented in their records. (Regulation 9 (3) (c))
- The service must ensure that young people have access to meaningful and varied activities to support their recovery during their admission. (Regulation 9 (3) (b))
- The service must ensure that there is clinical and managerial leadership in place on both wards to support staff to provide safe and effective care. (Regulation 18 (1))
- The service must ensure that effective governance arrangements are in place to monitor the quality of services provided and to ensure any shortfalls in care are identified and addressed promptly. (Regulation 17 (2) (a))

Action the service SHOULD take to improve:

- The service should ensure that stock items and equipment are stored away from areas designated for patient use.
- The service should ensure that sharps disposal bins are labelled with the date of assembly to improve the safety of waste storage at the hospital.
- The service should ensure that monitoring processes are in place to provide assurance that staff are completing observation checks on patients at the prescribed intervals, including at night.
- The service should continue to engage with and respond to the external stakeholders involved with patients in long term segregation to ensure effective oversight of patients' care and welfare.
- The service should ensure that systems for ordering stock and patient-specific medicines enable people to receive their medicines as prescribed.
- The service should ensure that all patient-specific medicines, including topical creams, are labelled with the details of the patient they have been prescribed to.
- The service should ensure that temperature checks are completed daily in relation to the medicines fridge to provide assurance that medicines are being safely stored.
- The service should review the process for management of incidents to ensure that de-briefs are available in practice where staff and/or patients would benefit from these.
- The service should explore ways in which ward-based staff could be more engaged in clinical audit and improvement activities.
- The service should review the arrangements for induction of agency staff to the wards to ensure that they are supported to care effectively for people with eating disorders.

Summary of this inspection

- The service should review the training available for staff on meeting the needs of autistic people to ensure this is adequate to support staff in meeting the needs of patients.
- The service should consider reviewing the requirements relating to cooking and baking activities to make these more accessible to people who are not yet on an oral diet.
- The service should consider how to increase the engagement of young people on Inca ward in community meetings.
- The service should consider if the blanket restriction on young people not having keys or fobs to access their bedrooms can be reviewed to reduce the restrictions on people's freedom of movement on the wards.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Inadequate	Requires Improvement	Inadequate	Inadequate

Inadequate

Specialist eating disorder services

Safe	Inadequate
Effective	Requires Improvement
Caring	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished and well maintained but they were not always fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff told us they carried out daily security checks on both wards.

Staff could not observe children and young people in all parts of the wards but blind spots were mitigated by mirrors and closed circuit television.

The ward complied with guidance and there was no mixed sex accommodation. All but two of the bedrooms were en-suite and the bedrooms which shared a bathroom were designated for female patients only. There were only female patients at the service when we inspected.

Staff knew about any potential ligature anchor points and mitigated the risks to keep children and young people safe. Staff completed annual audits of fixed ligature points, the most recent of which was in November 2023. Fixtures and fittings in bedrooms and en-suite bathrooms were anti-ligature. Ligature cutters were easily accessible to staff in the clinic rooms and nursing offices on both wards.

Staff had easy access to alarms and children and young people had easy access to nurse call systems. Staff carried alarms on their person and all bedrooms and communal areas had wall mounted alarm call panels.

Maintenance, cleanliness and infection control

Ward areas were mostly clean, well maintained and well-furnished but were not always fit for purpose. On Inca ward the patient lounge was a small off-shoot from the main corridor. This meant that people using the lounge were frequently

asked to move into their bedroom to protect the dignity of other patients if they were being supported to the nasogastric feeding room in restraint and/or were distressed. There was a safety pod being stored in an empty bedroom and we were told this was usually stored in the sensory room when this bedroom was in use. Due to the small size of the sensory room the safety pod would have taken up most of the floor space in this room. There were boxes of nasogastric feeds and syringes stacked up in the de-escalation area adjacent to the nasogastric feeding room and staff told us there was nowhere else to store these items. The fridge in the Inca ward dining room was dirty and some patients complained about an unpleasant smell from the sinks. Other than this we did not identify any issues with the cleanliness or safety of the premises and patients and relatives told us that the hospital was usually clean.

Staff made sure cleaning records were up-to-date and the premises were clean. We observed cleaning taking place on both wards throughout the course of the inspection. Cleaning records were maintained which showed that cleaning was taking place daily as required. A monthly infection prevention and control audit was carried out and actions were identified to address any issues this picked up.

Staff followed infection control policy, including handwashing. This was checked during monthly audits.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. A medical devices audit was carried out which included checks of the clinic room equipment. However, the sharps bins in both clinic rooms did not have the date of assembly recorded on them so it was not possible to confirm that waste sharps were being disposed of in a timely manner.

Staff checked, maintained, and cleaned equipment. We did not identify any poorly maintained or unhygienic equipment during our inspection of the clinic rooms on both wards. Records were kept which showed that all checks and calibrations of equipment were up to date.

Safe staffing

The service did not have enough nursing staff, who knew the children and young people. Staff did not always receive adequate training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep children and young people safe. Although records showed that shifts were usually staffed up to the establishment level, staff were not always able to meet people's needs due to the ratio of nursing staff to unqualified support staff (1 qualified nurse on Inca ward and 2 on Aztec ward but 1 of these was specifically assigned to 1 patient) and the high use of agency staff. Nursing staff told us they were unable to take breaks and did not always have time to offer one to one support to patients. We saw examples of nursing tasks not being completed in a timely manner such as updating risk assessments following incidents. This increased the risk of harm to the young people using the service. Some staff told us that they spent most of their time responding to incidents and there was not enough staff to meet the complex needs of the patients. Staff who were supposed to be supernumerary were expected to carry out tasks they did not feel comfortable doing due to staffing pressures. Staff who were specifically commissioned to care for 1 individual patient were sometimes being used to support the wider staff team.

Inadequate

Specialist eating disorder services

The service had high vacancy rates. Only 4 of the 12 full time nursing posts at the hospital were filled with permanent staff. One permanent nurse was on maternity leave, 5 vacancies were being filled by self-employed locum nurses and there were 2 vacant posts. The provider's figures showed that 27% of healthcare support worker posts were vacant at the time we inspected. In the multidisciplinary team there were a number of vacant posts including the social worker and clinical psychologist (although there was a trainee psychologist and an assistant psychologist in post). The substantive posts of family therapist and occupational therapist were also vacant, although there were locums for both roles working at the hospital at the time we inspected.

The service had high rates of bank and agency nurses and support workers. In the 6 months preceding our inspection agency staff worked 67% of the shift hours on Aztec ward and 40% of the shift hours on Inca ward. Patients told us they were often cared for by unfamiliar staff and gave examples of how this negatively impacted them, for example being held in lengthy restraint holds by staff members who did not know their name. The independent advocate told us they had identified this as a recent trend of concern from the feedback they received from patients.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff told us this included a tour of the ward, the location of the ligature cutters and emergency equipment, an overview of the key environmental and patient-specific risks and the medicines and supportive observations prescribed for each patient. However, staff and patients told us that some agency staff did not have any experience or training in working with eating disorders.

The service had high turnover rates. Staff told us that turnover was high and the hospital struggled to recruit and retain permanent staff. The provider's data showed that the turnover rate for the 12 months preceding our inspection was 45%. Several members of the multidisciplinary team had left the service since our last inspection.

Managers supported staff who needed time off for ill health. Staff who had been injured at work or who had needed time off for another reason told us they felt well supported by senior managers.

Levels of sickness were low. There were no staff members on long-term sickness absence at the time we inspected and the average rate of sickness absence for the 12 months preceding our inspection was 5%. However, we were concerned at the high rate of work-related injuries sustained by staff (19 injuries in the 6 months preceding our inspection). We witnessed a staff member being injured at work during the inspection.

Senior nurses and managers could adjust staffing levels according to the needs of the children and young people. However, it was not always possible to arrange for additional staff to attend in a timely manner. During the inspection we received feedback from ward staff that additional staff had been requested to support the team in dealing with new admissions to the ward but these additional colleagues had not arrived despite the team being given assurances by managers that they could have extra staff. Managers told us that additional staff had arrived as required, but acknowledged that staff still may have felt pressured due to the acute needs of the newly admitted patients.

Children and young people did not have regular one to one sessions with their named nurse. Staff and patients told us this did not happen regularly due to the pressures on nursing staff. We saw no evidence on the care records that patients were having regular one to one time with their named nurse, although some people's care plans stated this should be happening twice a week. The provider's physical interventions policy stated that all patients who were receiving nasogastric feeding under restraint should have a minimum of an hour a week one to one time with a key worker to support them and explore alternative options to the forced feeding but this was not happening.

Children and young people rarely had their escorted leave, or activities cancelled, even when the service was short staffed. People told us that leave and activities usually went ahead as planned. However, several patients told us there were few planned activities and they felt bored as there was nothing to do.

Restraint training was inconsistent which resulted in inappropriate restraint techniques being used by some staff working within the service. The high use of agency staff meant that staff were not always trained in the same restraint model, which risked harm to patients from inappropriate techniques being used or confusion relating to techniques used during restraints. Staff and patients told us that this happened regularly, and we witnessed this during a restraint for a nasogastric feed which we observed. Some agency staff had not received any restraint training but were still expected to participate in restraints due to the frequency of incidents occurring on the wards.

Staff shared key information to keep children and young people safe when handing over their care to others. People's community care coordinators were involved in their ongoing care during their admission and had the opportunity to attend Care Programme Approach reviews and MDT meetings at the hospital by video link.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was a full-time consultant and speciality doctor based at the hospital. However, some staff and patients told us that the consultant was not accessible to patients.

Managers could call locums when they needed additional medical cover. However, they told us that this was not generally necessary, due to there being 2 full time doctors at the hospital.

Mandatory training

Not all staff had completed and kept up-to-date with their mandatory training. The provider's training data showed that over 85% of permanent staff were up to date with all modules except for Level 3 safeguarding (82%), the ward-based nasogastric feeding induction module (60%), the healthcare support worker certificate (78%) and completion of the induction buddy booklet for healthcare assistants (71%). However, the service used a high proportion of agency staff, who had not completed the provider's full training programme.

The mandatory training programme for permanent staff was comprehensive and met the needs of patients and staff. Staff received training in a range of areas relevant to the services provided including eating disorders, autism awareness, moving and handling and restrictive practices. The staff we spoke with told us that their training supported them with all aspects of their role. However, due to the high use of agency staff we identified gaps in the training received by staff on the wards, for example permanent staff and agency staff being trained in different restraint techniques and some agency staff not having had any restraint or moving and handling training. Also, some nurses told us they had not had any restraint training due to healthcare assistants being prioritised for these courses. Staff also raised concerns about the level of NG feeding tube insertion training they had received before they were expected to carry out this task (watching a video and observing a colleague). Not receiving adequate training relating to NG tube insertion was also raised as a concern in exit interviews carried out with staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training compliance was monitored by the management team using an automated system which flagged up the dates

at which time-limited training modules expired. Compliance rates were discussed at regular team meetings and staff were prompted to complete modules which were out of date. However, this did not apply to some of the agency staff working at the service. The provider told us that there was a separate system for monitoring agency staff training compliance, including training provided by their agency and any additional training provided by the hospital.

Assessing and managing risk to children and young people and staff

Staff did not always assess and manage risks to children, young people and themselves well and did not follow best practice in anticipating, de-escalating and managing challenging behaviour. We identified concerns that restraint was being over-used at the service and we saw no evidence that ward staff participated in a restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each child and young person on admission, using a recognised tool, however risk assessments were not always reviewed in a timely manner following incidents. We identified an occasion when a risk assessment was not updated following an incident and the patient then experienced further harm which may have been preventable.

Management of patient risk

Staff generally knew about any risks to each child and young person but did not always act to prevent or reduce risks in a timely manner. Incidents causing harm to people using the service occurred during the inspection including significant incidents of self-harm and an injury during an episode of restraint.

Staff did not always record the risks presented by the individuals or take prompt responsive action to reduce the risks which had been identified and we were concerned this placed people at risk of harm. Some of the young people we spoke with told us that they did not feel safe on the ward and minutes of the weekly community meetings also showed young people repeatedly raising concerns about this. Some young people and their relatives also raised concerns about not being reviewed and supported appropriately after sustaining a head injury due to self-harming behaviour. In the 6 months preceding our inspection, the provider's data showed that 67 patient injuries were recorded, the majority of which were head injuries from self-harming.

Staff did not always follow procedures to minimise risks where they could not easily observe children and young people. Some patients told us that night staff did not always complete their supportive observations at the prescribed internals. It was not possible to establish if the risks to young people were always adequately assessed prior to them leaving the hospital due to lack of contemporaneous record keeping relating to this.

Staff followed policies and procedures when they needed to search children and young people or their bedrooms to keep them safe from harm. Searches were carried out when young people returned from leave and young people's preferences regarding searches were documented in their care records.

Use of restrictive interventions

Levels of restrictive interventions were high. The provider's records showed that, in the 12 months preceding our inspection there were 5899 instances of physical restraint at the hospital. The majority of the young people receiving care at the hospital were receiving twice daily non-consensual nasogastric feeds under restraint. This included young

people whose body mass index (BMI) was above the threshold at which this is recommended to be commenced in national guidance. Concerns about this had been highlighted by some stakeholders involved in people's care. There were a high level of blanket restrictions in use on both wards, such as a list of rules about what young people must and must not do at mealtimes, searching procedures and people not having free access to their bedrooms or outside space. Some of the young people told us and/or had written notes on their care records reflecting their views that they felt restrictions, particularly physical interventions, were used too often at the hospital. Several young people also told us or had previously raised concerns that they had been injured and/or experienced pain during restraint and we saw evidence of this in their care records. We were concerned from the feedback we received from staff that they understood that restrictions, for example on patients having access to their bedrooms during the day, were being imposed for behaviour management rather than therapeutic reasons. Some stakeholders told us they felt the absence of positive risk taking at the service was resulting in a lack of progress for patients.

We saw no evidence that staff participated in a restrictive interventions reduction programme in order to meet best practice standards. Some staff told us that they felt inadequately trained and supported in relation to the frequency and nature of the physical restraints they were expected to engage in as part of their role. Team meeting minutes showed that reducing restrictive practices was a standing agenda item but discussions relating to this appeared to be superficial and brief if they were occurring at all (the same standard statements were repeated across multiple monthly minutes). The hospital had a register of blanket restrictions in place on both wards, however this did not include all the blanket restrictions we observed. For example, young people not having keys to their bedrooms and a lack of free access to outside space, due to the garden being shared by adults and children, were not included within the blanket restrictions register. Safeguarding and reducing restrictive practices audits were carried out, which both included reviews of the use of restrictive interventions, however these did not identify the issues we found during the inspection.

Staff did not make every attempt to avoid using restraint by using de-escalation techniques and did not use restraint as a last resort which placed children and young people at risk of harm. Staff told us that they had been told to keep young people in restraint holds for a specific period of time following their feed regardless of their level of agitation. Several of the young people told us that staff were quick to resort to hands on restraint and did not engage with them to try to de-escalate situations to avoid the use of restraint. Both external stakeholders and the independent advocate told us about their concerns about the levels of restraint and its inappropriate use within the service that they had either witnessed or received patient feedback about.

All patients had a Patient Inclusion in Least Restrictive Interventions and Management Plan (PILRIMP) within their care records which included detailed information of how best to work with the individual to minimise the need for physical restraint. However, the feedback we received from patients, staff and relatives raised concerns that these plans were not being consistently followed in practice and we saw evidence that staff did not adhere to these plans. For example, male staff were involved in the restraints for a patient whose plan stipulated only female staff should be involved. Some staff told us that they did not feel confident to restrain patients and they needed more support in relation to this aspect of their role.

Staff did not always demonstrate that they understood the Mental Capacity Act definition of restraint and worked within it. Informal patients were able to come and go freely from the hospital, however we identified concerns around the assessment and management of risk for informal patients, which we felt was sometimes not seen as a separate issue by staff to the legal right of informal patients to leave the ward, for example a documented leave risk assessment for a patient's absence from the hospital not being completed due to their informal status.

Staff followed the National Institute for Health and Care Excellence guidance when using rapid tranquilisation. Within the last 12 months there had been 46 instances of rapid tranquilisation used within the service. Physical health checks were carried out in accordance with national guidance following rapid tranquillisation and documented in people's records.

There was no seclusion room at the hospital and we did not see any evidence that people were secluded in bedrooms or elsewhere. The provider had a policy in place to ensure that any seclusion which was carried out as a last resort would be managed appropriately.

Staff did not always follow best practice, including guidance in the Mental Health Act Code of Practice, if a child or young person was put in long-term segregation. External stakeholders had raised concerns about the level of restrictions experienced by patients in long-term segregation at the hospital. The external team supporting the care of patients in long-term segregation told us that the service did not always engage effectively with them. Senior managers told us that they believed they had engaged consistently with all external stakeholders involved with the care of people in long-term segregation to reduce restrictions as quickly as possible.

Safeguarding

Staff generally understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse. The provider had a named nurse and doctor for child safeguarding and the ward teams had a safeguarding lead.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff told us that they received training in relation to safeguarding children and vulnerable adults from abuse as part of their mandatory training requirements.

Staff kept up-to-date with their safeguarding training. Over 80% of staff at the hospital were up to date with safeguarding training at all levels at the time we inspected.

Staff could give clear examples of how to protect children and young people from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and partnership working with other agencies to protect young people from abuse was effective. Shortly before the inspection there had been an organisational safeguarding review undertaken by Rotherham Metropolitan Borough Council due to concerns raised by stakeholders about the safety and welfare of young people using the service. The provider had engaged with this appropriately and the outcome of the review was to close the organisational concerns with recommendations to the provider to undertake improvement actions.

Staff followed clear procedures to keep children visiting the ward safe. There were separate visiting areas where people could meet with relatives including children. There were clear procedures in place to ensure the children using the service did not mix with adult patients without being supervised, for example in the secure garden.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The staff we spoke with were familiar with the local process for raising concerns.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. However, records were not always updated in a timely manner when people's needs and risks changed.

Patient notes were comprehensive and all staff could access them easily. The service used a combination of electronic and paper records. Paper records were accessible to staff in the nursing office on each ward. Permanent staff and regular agency staff had log in access to the electronic records via terminals in the ward offices. Nurses and healthcare assistants were able to access patients' records including care plans and risk assessments.

Staff did not always make sure records were up-to-date and complete. Risk assessments and care plans were not always updated in a timely manner, for example following incidents. Risk assessments relating to absence from the hospital were not always documented in the young person's records or elsewhere. The post-feed support section within care records did not allow staff to record how long a patient had spent in restraint holds during nasogastric feeds. We saw some records of incidents where it was apparent that physical restraint had been used but the 'restrictive interventions' section of the record had not been completed.

When children and young people transferred to a new team, there were no delays in staff accessing their records. If a young person reaching the age of 18 transferred to the adult ward their records were immediately accessible on their new ward.

Records were stored securely. Paper records were stored in the locked staff office and electronic records were password protected.

Medicines management

The service did not effectively use systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each child or young person's mental and physical health but did not always take timely action make changes in response to these reviews.

Staff usually followed systems and processes when safely prescribing, administering, recording and storing medicines. However, we identified some concerns in relation to how PRN (as required) prescriptions were written up which could have led to the risk of a young person receiving a higher dose of a medicine than they had been prescribed. Staff and patients also told us that sometimes there were issues with medicines being out of stock which could lead to people not receiving their medicines for several days.

Staff reviewed children and young people's medicines regularly. Medicines were reviewed during the ward round we observed. We also spoke with an external specialist pharmacist who said they visited the hospital every two weeks to review all patients' prescription charts as part of their regular audit process. However, some of the young people and carers we spoke with said their medicines had changed since their admission to the service and they had not been given any explanation why or any information about the new medicines they had been prescribed.

Staff usually stored and managed medicines and prescribing documents in line with the provider's policy. Medicines and prescription charts were stored securely in the clinic room. However, we identified some gaps in the temperature logs for the medicines fridge on Aztec ward and topical creams were not always labelled with the details of the patient they were prescribed for. We also identified excess stock medicines in both clinic rooms. Staff confirmed these medicines would be removed and disposed of appropriately. This had also been identified as an issue in the hospital's recent pharmacy audits, which were carried out quarterly.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely. However, we were told that the service had not been generating action plans in response to alerts in a timely manner. This had been picked up through pharmacy audits and addressed.

Decision making processes were not adequately in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We identified a concern about high use of benzodiazepine medication (which is potentially sedating and can cause addiction) at the service, with several patients being prescribed increasing doses of benzodiazepines over time which suggests increasing tolerance to the medication. The consultant told us they were aiming to reduce the use of these medicines at the hospital. We did not see any evidence of the use of STOMP (Stopping the Over-Medication of People with a learning disability, autism or both) guidance at the service, although several patients had either a diagnosis of autism or this was strongly suspected and they were going through an assessment process. This included some of the patients who were taking high doses of multiple benzodiazepines.

Staff reviewed the effects of each child or young person's medication on their physical health according to NICE guidance. The provider had systems in place to ensure that, when people had been prescribed high-dose anti-psychotic medication, they received regular checks of their physical health as required.

Track record on safety

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children and young people honest information and suitable support. However, improvements were not made as a result of lessons learned from incidents.

Staff knew what incidents to report and how to report them. All the staff we spoke with were aware of the incident reporting requirements, for example the need to report all instances of physical intervention as a separate incident.

Staff raised concerns and reported incidents and near misses in line with the provider policy. The incident reporting system was integrated with the care records and easily accessible to staff.

The service had no never events on either ward.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and families a full explanation if and when things went wrong. The mandatory training requirements for all staff included a module on the duty of candour.

Managers did not always debrief and support staff and patients after any serious incident. Staff and patients said that debriefs did not often happen following incidents. The incident records almost always stated that staff and patients had declined these which did not align with the feedback we received.

Managers investigated incidents thoroughly. However, children, young people and their families were not always adequately involved in these investigations. Staff also told us that they did not usually get any feedback in relation to incidents they reported. Stakeholders told us that they were not given information about incidents involving young people they were involved with when they asked for this.

Inadequate

Specialist eating disorder services

It was not always apparent that changes had been made as a result of lessons learned from incidents. Staff told us that they were given information about lessons learned from incidents at team meetings and the provider also sent staff a monthly lessons learned newsletter with information about changes made as a result of learning from incidents. However, we saw repeated concerns arising which mirrored the incidents described in the newsletter, which indicated that the actions taken to improve practice had been ineffective.

Managers shared learning with their staff about incidents that happened elsewhere. The lessons learned newsletter included information sharing about incidents that happened at other Ellern Mede hospitals.

Is the service effective?

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all children and young people on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, the frequency of reviews was not always in line with the provider's policy. Care plans reflected children and young people's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each child or young person either on admission or soon after. All the records we reviewed included a mental health assessment and managers told us that these were completed within 72 hours of admission. Young people also had a 72-hour care plan in place to assist staff in supporting them from the point of admission.

Children and young people had their physical health assessed soon after admission and regularly reviewed during their time on the wards. The admission paperwork included an assessment of the physical health of each person and we saw evidence on people's records that their physical health was regularly reviewed. Physical observations were carried out and the National Early Warning Score system (NEWS2) was used to monitor people's physical health.

Staff developed a comprehensive care plan for each child or young person that met their mental and physical health needs. People had care plans in place in relation to a range of mental and physical health needs to support their recovery from their eating disorder. The provider regularly audited care plans and the most recent audit had not identified any concerns with the documentation.

Staff regularly reviewed and updated care plans when children and young people's needs changed. The provider's standard was for monthly reviews, however some records we looked at showed that staff were not always meeting this standard.

Care plans were personalised, holistic and recovery-orientated. The care plans we reviewed included information on the individual needs and preferences of each individual to ensure the care they received was person-centred.

Best practice in treatment and care

Inadequate

Specialist eating disorder services

Staff provided a range of treatment and care for children and young people, however this was not always based on national guidance and best practice. They usually ensured that children and young people had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Although staff provided a range of care and treatments suitable for the children and young people in the service, staffing vacancies within the multi-disciplinary team resulted in the children and young people not having adequate access to psychological therapies to support their recovery. The patient information for the hospital stated that young people would receive psychotherapeutic interventions including individual and group therapy but there was no group therapy taking place and most of the young people were also not receiving any regular individual therapy. We saw some comments from young people in their care records that they would like to have more access to psychological therapies at the hospital.

Staff did not always care for young people in line with best practice and national guidance. For example, we observed young people receiving non-consensual nasogastric feeds when their BMI was above the threshold at which this intervention is recommended in national guidance for the preservation of life and restoration of physical and mental health. The rationale for this and the frequency at which this was being reviewed was not always clear from people's records. Young people were also not receiving psychological interventions as recommended by national guidance – there was no clinical psychologist at the service and a locum family therapist had only recently commenced in post.

Staff identified children and young people's physical health needs and recorded them in their care plans. The records we reviewed included individualised care plans for people's physical health needs. Ward staff told us they felt comfortable supporting people in relation to their physical health needs. Staff had received training in carrying out physical observations, which were completed several times a day for all patients.

Staff made sure children and young people had access to physical health care, including specialists as required. This included arranging for physical healthcare specialists to attend the hospital when patients were not able to safely leave. However, during the inspection we witnessed a delay in a patient being supported to access urgent physical healthcare.

Staff met children and young people's dietary needs, and assessed those needing specialist care for nutrition and hydration. Most of the young people were receiving nasogastric feeds to support their weight restoration. Dietary needs and preferences, such as allergies and plant-based diets were taken into account in the selection of an appropriate feed preparation for each individual. Where young people were taking an oral diet, their food and fluid intake was monitored, and all the young people had the opportunity to have regular one to one sessions with a member of the hospital's dietetics team. The occupational therapy team also supported young people with activities related to healthy nutrition, such as food shopping, meal planning and cooking. A daily breakfast club activity was held to provide a social opportunity for the young people from both wards and to encourage healthy eating patterns.

Staff helped children and young people live healthier lives by supporting them to take part in programmes or giving advice. The records we reviewed showed that young people were having regular sessions with the dietetics and occupational therapy teams as part of their holistic programme of recovery. However, there was a lack of planned activities which young people could engage in. Cooking and baking activities were taking place weekly on both wards but there was a strong expectation that young people would eat whatever they made during these activities and most of the young people at the hospital were not consuming any food orally at the time we inspected.

Staff used recognised rating scales to assess and record the severity of children and young people's conditions and care and treatment outcomes. The Health of the Nation Outcome Scales (HoNOS) were used and the provider also used internal key performance indicators to monitor outcomes for people.

Staff used technology to support children and young people. Due to most of the young people being admitted out of area, video conferencing facilities were used to maintain links with their home care teams and commissioners.

Staff did not take part in clinical audits, benchmarking and quality improvement initiatives. These were led by managers but the ward staff we spoke with told us that they did not have the capacity to be significantly involved in quality improvement work due to the pressures of work on the ward.

Managers did not consistently use results from audits to make improvements. Actions from audits were amalgamated in an overarching action plan which was reviewed monthly at clinical governance meetings. However, we saw a range of concerns during our inspection which either had not been picked up by the provider's governance processes or which had not been adequately addressed by improvement actions.

Skilled staff to deliver care

Managers provided an induction programme for new staff. However, the ward teams did not always have access to the full range of specialists required to meet the needs of children and young people on the ward. Managers did not always make sure they had staff with the range of skills needed to provide high quality care. Staff were not effectively supported with appraisals, supervision and opportunities to update and further develop their skills.

The service did not have sufficient access to a full range of specialists to meet the needs of the children and young people on the ward. Due to staffing vacancies at the time we inspected, there was no qualified clinical psychologist or social worker based at the hospital and a locum family therapist had only recently commenced in post.

Managers ensured permanent staff had the right skills, qualifications and experience to meet the needs of the children and young people in their care, including bank and agency staff. However, we identified concerns about inconsistency of restraint techniques being used due to permanent and agency staff being trained in different models. Some young people also raised concerns about agency staff not having any knowledge or experience in relation to eating disorders.

Managers gave each new member of staff a full induction to the service before they started work. The permanent and regular agency staff we spoke with told us they had received an induction before commencing work at the service. We saw a template ward induction record which staff said any new agency staff had to complete on arrival for their first shift. Agency workers were also given an information pack about the ward with a summary of key policies and procedures relevant to their role.

Managers did not consistently support staff through regular, constructive appraisals of their work. The provider's monitoring data showed that 69% of staff had received an appraisal within the last 12 months. Of the staff who were not up to date with their appraisal, 4 were on maternity leave at the time of our inspection.

Managers did not consistently support staff through regular, constructive clinical supervision of their work. On Inca ward, 67% of nurses received supervision in January 2024. On Aztec ward 48% of support workers received supervision in January 2024. The provider told us that support workers received a supervision every two months and the remaining 52% of support workers would receive an appraisal in February 2024, however we have not seen any evidence to confirm that this happened.

Managers made sure staff attended regular team meetings or gave information to those who could not attend. Staff told us that team meetings took place and they received email updates in addition to the information shared at meetings.

Managers did not always identify the training needs of their staff or give them the time and opportunity to develop their skills and knowledge. Several staff members told us they did not feel sufficiently supported in relation to their training needs around physical restraints. Some patients told us they had experienced one or more restraints by someone with inadequate training, which was distressing for them. During our observations, we noted some staff members did not appear confident when restraining patients.

Managers did not always make sure staff received specialist training for their role. There were young people within the service living with autism. Although there was online training available, some staff did not feel this sufficiently supported them in understanding and meeting the needs of autistic people. However, the service had recently created a new role of autism champion to further support staff in working with autistic people.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit children and young people. However, the ward teams did not always have effective working relationships with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss children and young people and improve their care. The multidisciplinary and management teams held daily communication meetings during which any significant changes to each young person's care were discussed. However, due to staffing vacancies, for example in the psychology team, and a number of roles being filled by locum staff, there were gaps in young people's care.

Staff made sure they shared clear information about children and young people and any changes in their care, including during handover meetings. We observed part of a ward handover at which information was shared with the incoming ward team. Records were kept of handover meetings using a standard template which prompted staff to review key areas of risk.

Ward teams usually had effective working relationships with other teams in the organisation. However, some staff told us that written communication from night staff was not always of good quality.

Ward teams did not always have effective working relationships with external teams and organisations. Some commissioners fed back to us that the hospital communicated effectively with them in relation to their patient's care. Care coordinators were able to attend their patient's ward round meetings using video conferencing facilities. However, some commissioners and external teams told us they felt excluded by the service, to the detriment of the patient they were supporting.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain children and young people's rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Staff told us they had completed Mental Health Act training as part of their mandatory training and they felt this covered what they needed to know to support people appropriately and comply with the requirements of the Act. However, this was not included as a separate module in the induction and training information we saw.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The Mental Health Act administrator was on long term leave at the time we inspected. This role was being covered by another Mental Health Act administrator within the provider organisation working across 2 sites.

Staff knew who their Mental Health Act administrators were and when to ask them for support. The staff we spoke with knew how to contact a Mental Health administrator for support as needed.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice which staff could access via the provider's intranet. Staff received updates to policies and procedures via email.

Children and young people had easy access to information about independent mental health advocacy and children and young people who lacked capacity were automatically referred to the service. We received feedback from the independent advocate who told us that they visited the ward each week and they found the management team to be responsive to their feedback.

Staff explained to each child or young person their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the child or young person's notes each time. Records included evidence that staff reminded young people of their rights under the Mental Health Act at the intervals required by the Mental Health Act Code of Practice.

Staff made sure children and young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Young people told us they were generally able to go out on leave where this had been agreed.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. The Mental Health Act paperwork for each patient showed that, where an individual's care required authorisation by a SOAD, this was taking place as required.

Staff stored copies of children and young people's detention papers and associated records correctly and staff could access them when needed.

Children and young people admitted to the service informally knew that they could leave the ward freely and the service displayed posters to tell them this. The informal patients who were at the hospital when we inspected did not experience any inappropriate restrictions of their liberty.

Care plans included information about after-care services available for those children and young people who qualified for it under section 117 of the Mental Health Act. Discharge plans within the records we reviewed included information about section 117 after-care.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The external specialist pharmacist audited Mental Health Act paperwork in relation to patients' medicines every two weeks. Mental Health Act audits were also carried out, most recently in June 2023. Actions from audits were amalgamated in an overarching action plan and progress against this was monitored at clinical governance meetings.

Good practice in applying the Mental Capacity Act

Staff supported children and young people to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for children and young people who might have impaired mental capacity or competence.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Staff told us their mandatory training included online learning about the Mental Capacity Act and 93% of staff were up to date with this at the time we inspected.

There were no Deprivation of Liberty Safeguards applications made in the last 12 months in relation to patients at the hospital.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff knew how to access. Policies and procedures were available to staff via the provider's intranet.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gave children and young people all possible support to make specific decisions for themselves before deciding a child or young person did not have the capacity to do so. Where people had specific communication needs, these were documented in their records so staff knew to provide them with support to express their views and make decisions about their care.

Staff assessed and recorded capacity to consent clearly each time a child or young person needed to make an important decision. The Mental Health Act documentation included documented capacity assessments when these were required. Staff told us that the doctors updated these every two weeks.

When staff assessed a child or young person as not having capacity, they made decisions in the best interest of the child or young person and considered their wishes, feelings, culture and history. However, we were concerned by the practice of non-consensual nasogastric feeding taking place when the patient was above the threshold BMI where this is recommended as appropriate practice in national guidance. Although patients receiving this were always detained under the Mental Health Act, the rationale for the continuation of non-consensual feeds once the patient had reached a healthy weight was not always clearly documented in people's records.

Inadequate

Specialist eating disorder services

The service monitored how well it followed the Mental Capacity Act and made and acted when they needed to make changes to improve. Regular audits on compliance with the Mental Capacity Act took place, most recently in January 2024. Capacity assessments kept with people's Mental Health Act paperwork were also monitored via the external pharmacy audits.

Staff understood how to support children under 16 wishing to make their own decisions in line with Gillick competence. Staff received training on consent and capacity covering both children and adults as part of their mandatory training requirements.

Staff knew how to apply the Mental Capacity Act to young people aged 16 to 18 and where to get information and support on this. This was included in the training staff received and was monitored via the Mental Capacity Act audit.

Is the service caring?

Inadequate

Kindness, privacy, dignity, respect, compassion and support

Staff did not always treat children and young people with compassion and kindness and there were times when children and young people's privacy and dignity were not respected. Staff usually understood the individual needs of children and young people but did not always support them to understand and manage their care, treatment or condition.

Staff were not always discreet, respectful, and responsive when caring for children and young people. We identified some occasions where young people's privacy and dignity was not respected. We observed young people being taken in restraint holds to the nasogastric feeding room past the sensory room and other patients' bedrooms, in earshot of other patients and visitors on both wards. Staff tried to mitigate this by asking people to move away from the main corridor before this happened. During our Mental Health Act monitoring visit in January 2024, we identified that people's dignity when using the bathroom was not always supported as the patient was being continually observed by multiple staff members. We observed staff speaking in a derogatory way about patients and relatives in the nursing office. Some of the young people told us that staff did not always knock before entering their room.

Staff did not always give children and young people help, emotional support and advice when they needed it. We observed staff were sometimes too busy to offer emotional support to the young people. The patients we spoke with said they did not feel like staff had time for them and some young people struggled to build relationships with staff due to the high numbers of agency staff working at the service.

Staff did not always support children and young people to understand and manage their own care, treatment or condition. The young people we spoke with had not been given enough information about their care, for example about the medicines they were taking. Vacancies in the psychology team and the lack of one to one time with qualified nurses resulted in young people feeling inadequately supported to understand and manage their eating disorder.

Not all of the children and young people within the service felt staff treated them well or behaved kindly towards them. Young people raised concerns about being restrained too often and by staff who did not interact with them. We observed staff talking between themselves and not involving the individual during a lengthy restraint, which caused the individual distress. Some young people told us that night staff were not always respectful and polite to them.

Staff did not always understand and respect the individual needs of each child or young person. Young people told us that they were often cared for by unfamiliar staff due to the high use of agency staff at the hospital and that agency staff in particular did not always understand eating disorders. Staff did not always respect individuals' preferences despite them being documented in their care records.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards children and young people. Staff we spoke with said they would feel comfortable to raise concerns if they were concerned about a colleague's actions.

Staff followed policy to keep patient information confidential. Staff kept records secure and we did not observe any inappropriate sharing of confidential information during our time on the wards.

Involvement in care

Staff actively sought feedback from children, young people and their families on the quality of care provided. They ensured that children and young people had easy access to independent advocates. However, staff did not always adequately involve children, young people and their families in care planning and risk assessment.

Involvement of children and young people

Staff introduced children and young people to the ward and the services as part of their admission. We observed the admission of a patient on Inca ward, which included a tour of the ward and an introduction to staff members.

Staff did not always involve children and young people or give them access to their care planning and risk assessments. Young people told us that they had not been offered copies of their care plans or risk assessments and some people felt staff did not listen to their views about their care and treatment. However, during the multi-disciplinary meeting we observed there was detailed consideration of the young person's views by the team. Patients were invited to attend the multi-disciplinary reviews, with the support of an independent advocate if needed. A number of patients at the time we inspected had a diagnosis of autism or were undergoing assessment and their care records included information on how they preferred to be supported to communicate their needs where this support was needed.

Staff attempted to involve children and young people in decisions about the service, when appropriate. Community meetings took place weekly on both wards, we observed 2 of these meetings and reviewed minutes which showed that young people were asked for their views on changes to the service at these meetings. However, minutes of the meetings on Inca ward particularly showed that young people did not frequently engage in these meetings and on multiple occasions in December 2023 the meeting was cancelled as no one wished to attend. However, the minutes for Inca ward from earlier in the year showed the engagement of the young people in decisions about redecorating the communal areas of the ward.

Children and young people could give feedback on the service and their treatment and staff supported them to do this. Young people on both wards were asked for their views at regular community meetings on both wards and they also had the opportunity to complete a feedback survey.

Staff supported children and young people to make decisions on their care. Information about any additional support which would help people to communicate their views was included in their care records.

Inadequate

Specialist eating disorder services

Staff made sure children and young people could access advocacy services. An independent advocate visited the ward weekly and supported young people at their multi-disciplinary team reviews as needed. The advocate prepared a monthly report for managers including a summary of the types of support offered to patients and the main themes from the information they had shared.

Involvement of families and carers

Staff usually informed and involved families and carers appropriately.

Staff supported, informed and involved some families or carers, but some of the relatives and carers we spoke with told us that they did not feel as involved as they would like to be in their relative's care. In some cases this was due to the patient being aged 16 or over and not consenting to sharing information with their family.

Staff helped families to give feedback on the service. The carers we spoke with told us they had opportunities to share their views about the service and their relative's care.

Staff gave some carers information on how to find the carer's assessment, but some carers told us they had not been given any information about this by the service.

Is the service responsive?

Requires Improvement

Access and discharge

Staff generally planned and managed the discharge of children and young people well. They usually worked well with services providing aftercare and managed children and young people's move out of hospital. However, some external partners told us that staff did not always engage effectively with them. Children and young people did not have to stay in hospital when they were well enough to leave

Managers regularly reviewed length of stay for children and young people to ensure they did not stay longer than they needed to. The average length of stay for the patients at the hospital at the start of our inspection was 718 days.

The service had high out-of-area placements due to the specialist nature of the services provided.

Managers and staff worked to make sure they did not discharge children and young people before they were ready.

When children and young people went on leave there was always a bed available when they returned.

Children and young people were moved between wards during their stay only when there were clear clinical reasons or it was in their best interest. We saw that transfers from the children's ward to the adult ward only took place when this was in people's best interests once they reached the age of 18 and people were well supported during this process. Staff did not move or discharge children and young people at night or very early in the morning.

Discharge and transfers of care

Managers monitored the number of children and young people whose discharge was delayed. Due to the small size of the hospital the management team were familiar with each individual patient's care pathway.

Children and young people did not have to stay in hospital when they were well enough to leave. There were no patients at the hospital at the time we inspected who were well enough to be discharged. Discharges were sometimes delayed due to a lack of suitable community provision for the young people, however managers and the multi-disciplinary team communicated with young people's care coordinators and home care teams to progress discharge plans as quickly as possible.

Staff carefully planned children and young people's discharge and worked with care managers and coordinators to make sure this went well. We observed discussions relating to discharge planning taking place at the Care Programme Approach and multi-disciplinary team meetings we observed. However, the young people and carers we spoke with did not feel adequately involved in the discharge planning process.

Staff supported children and young people when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

Each child and young person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality. However, the design, layout, and furnishings of the wards did not always support children and young people's treatment, privacy and dignity.

Each or young person had their own bedroom, which they could personalise. The young people we spoke with were happy with their bedrooms and could personalise them with their own items. Some of the young people showed us their rooms, which had been personalised with posters and other items. However, young people did not have keys or fobs to access their rooms and so they were dependent on staff to access their bedrooms. Some young people told us this could lead to them not being able to access their room when they were not able to get the attention of a staff member.

Children and young people had a secure place to store personal possessions. All the young people had a secure storage locker in their bedroom.

Staff used a full range of rooms and equipment to support treatment and care. Each ward had a small sensory room in addition to the patient lounge. There were also an activities room and therapy rooms which were shared by the two wards.

The service had quiet areas and a room where children and young people could meet with visitors in private.

There was a lack of communal space on Inca ward due to the lounge area not being separate from the main corridor and the sensory room being used to store the safety pod, which took up a lot of the floor space.

Children and young people could not always make phone calls in private. The young people had their own phone which they could use in their bedroom to make calls. However, due to the high number of patients who were being continuously observed by staff, most patients were not able to make phone calls privately.

The service had an outside space; however children and young people could not access this easily. As the secure garden was shared by both wards, patients who were under 18 could only access this with staff supervision due to the presence of older people which prevented them from having regular access to outside space.

Children and young people could not make their own hot drinks and snacks due to the specialist nature of the service requiring careful monitoring of their dietary intake. Where young people were taking food and fluids orally, they had regular access to hot drinks and snacks and were supported by the occupational therapy and dietetic teams in relation to their diet.

The service offered a variety of good quality food.

Children and young people's engagement with the wider community

The service made sure children and young people had access to high quality education throughout their time on the ward. However, staff did not regularly support children and young people with activities outside the service.

Staff made sure children and young people had access to opportunities for education and work and supported them. There was a registered school on site which some of the young people attended. Young people who were over 16 were able to leave the hospital and attend further education when they were well enough to do so.

Staff helped children and young people to stay in contact with families and carers. Young people had their own phones which they could use to stay in regular contact with friends and relatives. The service also supported families to visit their relatives as frequently as possible.

Staff encouraged children and young people to develop and maintain relationships both in the service and the wider community. Young people were supported to maintain relationships when they moved between the children's ward and the adult ward after turning 18, where this was appropriate and safe for all the patients involved. The morning breakfast club was an opportunity for patients from both wards and staff to socialise in a supportive environment.

Young people told us that they did not have access to a variety of meaningful activities on the ward or in the local community during their admission. We did not observe any young people being supported with community-based activities other than attending further education during our time on the wards.

Meeting the needs of all people who use the service

The service met the needs of all children and young people – including those with a protected characteristic. Staff helped children and young people with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. There were accessible bedrooms on both wards for people with additional mobility needs and people's communication needs were explored and included in their care plans, for example when they had a diagnosis of autism. The service had recently created a new role of autism champion to support staff in working with autistic young people.

Staff made sure children and young people could access age-appropriate information on treatment, local service, their rights and how to complain. Information was displayed on noticeboards on both wards.

The service had information leaflets available in languages spoken by children, young people and the local community. These could be provided to people on request.

Managers made sure staff, children and young people could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual children and young people. People's dietary and cultural needs were taken into account in the selection of appropriate nasogastric feeding preparations for each patient who did not have any oral food intake. We reviewed sample menus which showed a range of food was available to meet different cultural and dietary needs.

Children and young people had access to spiritual, religious and cultural support. People's religious and cultural needs were included as part of their admission assessment. None of the people we spoke with raised concerns about a lack of access to spiritual support.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously and investigated them, however we did not see evidence that the service learned lessons from complaints and shared these with the whole team and wider service.

Children, young people, relatives and carers knew how to complain or raise concerns. The people we spoke with told us they knew how to raise concerns and relatives who had needed to raise a complaint told us they had been provided with a copy of the complaints policy. However, where young people or their relatives had raised concerns, for example about over-use of restraint, they said this did not result in any change to practice.

The service clearly displayed information about how to raise a concern in patient areas. The internal complaints process and information about how to contact CQC were displayed on noticeboards on both wards. There was also information about the complaints process in the patient information leaflet given to the young people on admission to the service.

Staff understood the policy on complaints and knew how to handle them. The staff we spoke with knew how to support people if they wished to formally complain about their care.

Managers investigated complaints and identified themes. An annual analysis of complaints information was carried out to ensure any themes of concern were identified. Levels of complaints were low (3 in 2022 and 9 in 2023).

Staff protected children and young people who raised concerns or complaints from discrimination and harassment. We saw no evidence during the inspection that young people had experienced any negative outcomes from having raised concerns.

Children, young people and their families did not always receive feedback from managers after the investigation into their complaint. Some of the young people and their families told us that they had raised concerns, but they had not received any feedback in relation to them.

Managers shared feedback from complaints with staff, however we did not see how learning was used to improve the service. An annual summary of complaints was prepared and shared with staff, which included information about lessons learned from complaints. However, people using the service and relatives who had raised complaints told us that this did not result in any positive change for them.

Inadequate

Specialist eating disorder services

The service used compliments to learn, celebrate success and improve the quality of care. Compliments about the service were logged as well as complaints and this information was shared with staff.

Is the service well-led?

Inadequate

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were approachable for children, young people, families and staff. However, people told us that senior leaders were not visible or accessible in the service.

Staff, patients and relatives generally spoke highly of the senior leaders and said they were knowledgeable and approachable. However, staff did not feel well supported and said they did not often see senior leaders on the wards. Relatives felt senior managers at the hospital were very busy and they were not always easy to get hold of or quick to respond to any queries or concerns when they were raised. At the time we inspected, there were no ward managers for either of the wards. The deputy hospital manager and clinical services manager undertook ward management responsibilities as part of their roles. Some staff told us that they had felt better supported when there had been separate ward managers in post and that the absence of separate ward managers increased the pressures on qualified nurses.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff told us that their corporate induction included information on the provider's vision and values and these felt meaningful to their day to day work. The provider's training data showed that 96% of permanent staff were up to date with the Ellern Mede values module of the mandatory training programme.

Culture

Staff did not feel respected, supported and valued. They did not feel they had opportunities for development and career progression. However, they said the provider promoted equality and diversity in its daily work.

Most of the staff we spoke with told us that the pressures of work were negatively impacting on their wellbeing. They said they had raised concerns about this within the hospital but action had not been taken to address the problem. Staff told us that morale on the wards was low due to the challenging nature of their role and the lack of support from the organisation.

Not all of the staff within the service felt able to raise concerns without fear of reprisals. Staff also said no action had been taken in relation to any concerns they had raised so far. We were told that a Freedom to Speak Up Guardian from Ellern Mede attended the site regularly and they were able to speak with them privately if needed.

Staff told us managers and colleagues were very supportive of religious and cultural diversity.

Inadequate

Specialist eating disorder services

Staff had the opportunity to complete an annual feedback survey. The report of the 2022/23 survey showed staff satisfaction to be lowest at Ellern Mede Moorgate out of the whole Ellern Mede group of 4 hospitals nationally. We did not see any evidence of how the provider planned to address this.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

We identified significant concerns during the inspection which had not been picked up by the provider's internal governance processes. These issues were negatively impacting the safety, human rights and physical and psychological wellbeing of patients as well as the wellbeing of staff.

We found that restrictive practices were overused and this was causing psychological distress and physical harm to patients. The provider's systems to monitor the use of restrictive practices had not enabled staff to identify and address these concerns.

We found that risks relevant to the care of young people were not always being effectively identified and addressed through the risk assessment and care planning processes and these concerns had not been identified and addressed through the provider's governance systems.

We found that the provider's systems for staff to report and investigate incidents and complaints were not resulting in lessons being learned when things went wrong and improvements were not being put in place to prevent a recurrence of these concerns.

We found that feedback from young people using the service, staff and stakeholders was not being consistently taken into account and actioned to ensure that concerns were resolved and ongoing improvements were made to the service.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care but did not use that information to good effect.

The morning communication meeting was attended by the nurse in charge from each ward so that information about patient-specific and other risks could be collated on a daily basis. However, due to the significant safety issues we identified during the inspection, we did not find that information about risk was being used to ensure safe and effective care for young people using the service.

Information management

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, we did not see any evidence that staff engaged actively in local and national quality improvement activities.

Information was in an accessible format. The provider used a bespoke information management system for care and governance records which was accessible to staff. However, information was not always updated in a timely way.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. However, the provider's systems did not support the consistent and timely identification of and response to areas for improvement or concerns about the quality of care.

Information governance systems included confidentiality of patient records. Information was stored securely and we saw no evidence of any inappropriate sharing of confidential information.

Staff made notifications to external bodies as needed. We did not identify any concerns during our inspection which required notification to the Care Quality Commission and which had not been notified appropriately.

Engagement

Managers did not always effectively engage with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

As a specialist service the hospital accepted patients from all over the UK. Most commissioners and care coordinators told us that the hospital engaged well with them. However, some commissioners raised concerns that they found the senior management team difficult to engage with and said they had raised concerns about their patient's care which had not been addressed to their satisfaction.

Other stakeholders, for example local safeguarding teams and specialist teams, also expressed concerns to us about how the provider engaged with the local health and social care system.

The service had attempted to improve engagement with relatives by setting up online carers forums but there had been limited involved with these at the time we inspected.

Community meetings were held weekly on both wards to promote engagement with the young people using the service. The registered manager said there were plans being developed to involve patients in more aspects of the running of the service, for example staff recruitment.

Learning, continuous improvement and innovation

At the time we inspected the service was trialling the use of genetic testing for some patients to enable more individualised and targeted treatment with medication. The medical team told us that this was increasing the positive impact of patients' treatment with medication.

The registered manager of the hospital was also the autism lead for the Ellern Mede Group. The role of autism champion had been piloted at Ellern Mede Moorgate and was planned to be rolled out to the whole group due to positive feedback about the impact of this additional post. However, this work was in its early stages at the time we inspected.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider did not ensure that staff treated patients with kindness, respect and compassion or had adequate support in relation to wellbeing issues which could lead to compassion fatigue. (Regulation 10 (1)) The provider did not ensure that the arrangements for nasogastric feeding, toileting and bathing adequately supported the privacy and dignity of people or avoided unnecessary distress. (Regulation 10 (2) (a))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not ensure that young people had access to psychological therapies in line with national guidance on eating disorders where this had been assessed as appropriate to support their recovery. (Regulation 9 (3) (b)) The provider did not ensure that young people had access to meaningful and varied activities to support their recovery during their admission. (Regulation 9 (3) (b)) The provider did not ensure that people using the service had regular one to one time with their named nurse. (Regulation 9 (3) (c)) The provider did not ensure that young people and, where appropriate, their families and carers, were involved in their care to the greatest extent possible or that attempts to involve people in their care were documented in their records. (Regulation 9 (3) (c))

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **s29 Warning Notice** Failing to comply with Regulation 18, 18(1) and 18(2)(a), Staffing, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that risk assessments were reviewed and updated as soon as possible following incidents which indicated a change to the risks relating to the individual's care. (Regulation 12 (2) (a)) The provider did not ensure that any risks relating to a period of absence from the hospital were considered and documented prior to the patient leaving the ward. (Regulation 12 (2) (a)) The provider did not always ensure that people were reviewed by a qualified clinician as soon as possible after any head injury or that people who needed urgent physical healthcare were supported to access this without delay. (Regulation 12 (2) (b)) The provider did not ensure that all staff who may have to undertake physical interventions as part of their role were trained to use the restraint techniques used at the service before working on the wards. (Regulation 12 (2) (c)) The provider did not ensure that all staff responsible for the insertion of nasogastric feeding tubes were trained and signed off as competent to perform this task before doing so. (Regulation 12 (2) (c))

This section is primarily information for the provider

Enforcement actions

The provider did not adequately protect people from being subjected to excessive restrictions due to the type and quantities of medication they had been prescribed or that national guidance on stopping the over-medication of people with a learning disability, autism or both (STOMP) was being taken into account where relevant. (Regulation 12 (2) (g))

Section 31 HSCA Urgent procedure for suspension, variation etc.

Conditions have been imposed on the provider's registration in respect of the above regulated activities as follows:

1. The registered provider must not admit any new service user to Ellern Mede Moorgate without the prior written agreement of the Care Quality Commission.

2. The registered provider must undertake a review, led by a senior clinician (consultant psychiatrist or registered mental health nurse at the equivalent level of Agenda for Change Band 8a or higher) with expertise in eating disorders independent to Ellern Mede Moorgate, of all patients receiving nasogastric feeding at Ellern Mede Moorgate to ensure that their care is being delivered in line with national guidance in each individual case and to share the outcome of this with the Care Quality Commission by 29 February 2024.

3. The registered provider must share a copy of the report and any action plan from the site level governance review referred to in the letter dated 29 January 2024 in response to the Care Quality Commission's letter of intent dated 26 January 2024 as soon as this is complete and no later than 29 February 2024.

4. The registered provider must ensure that a report is provided to the Care Quality Commission on Thursday 8 February 2024 and every Thursday thereafter by 10am which must include but is not limited to, the following information from the preceding 7 days:

a. A summary of all incidents involving service users that have occurred at the location.

b. A summary of any complaints or concerns raised by patients, relatives, carers, stakeholders or staff about the location.

This section is primarily information for the provider

Enforcement actions

c. Copies of any internal or external audits undertaken at the location, including but not limited to medication audits and care records audits.

d. A summary of the staffing for each ward for both day and night shifts for each 24 hour period showing the establishment for each shift, any additional staff required due to enhanced observations, the skill mix and the breakdown of permanent, locum agency and agency staff.

e. Minutes of any meetings of the Moorgate Improvement Group.

f. An update on progress of the site level governance review and the patient reviews while these remain ongoing.

We have taken this urgent action as we believe people will or may be exposed to the risk of harm if we do not do so.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **s29 Warning Notice** Failing to comply with Regulation 17, 17(1), 17(2)(a), 17(2)(b), 17(2)(c), 17(2)(e)and 17(2)(f), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.