

South West London and St George's Mental Health NHS Trust

Specialist eating disorders service

Inspection report

Trinity Building
Springfield University Hospital, 15 Springfield Drive
London
SW17 0YF
Tel: 02035135000
www.swlstg.nhs.uk

Date of inspection visit: 30 and 31 March 2022
Date of publication: 15/06/2022

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Our findings

Specialist eating disorders service

Good  

We carried out this short notice announced focused inspection in line with our inspection methodology. This inspection included a follow up on our last inspection to see if improvements had been made at the service.

Avalon Ward is an 18-bed national, specialist service providing care and treatment for male and female patients over the age of 18, experiencing severe eating disorders. On the day of the inspection the ward had a reduced bed capacity of 15 with all beds occupied.

Wisteria Ward is a 12-bed ward for male and female young people between the ages of 11 and 18 with severe eating disorders and weight loss related to mental health problems. It is a national service and accepts referrals from across the country. At the time of the inspection the ward was located in temporary accommodation with a reduced bed capacity of seven beds which were all occupied.

The trust advised us that both wards would be back at full capacity by July 2022.

In addition, the trust has an eating disorders day unit operating Monday to Friday during office hours which accommodates up to ten male and female patients over the age of 18 years. The service is for patients with a diagnosed eating disorder and who require a more intensive treatment programme of care and treatment than could be offered by the community mental health teams. We did not inspect this service.

South West London and St George's Mental Health NHS Trust specialist eating disorders services were last inspected in September and October 2019, when the overall rating for service was Requires Improvement. Safe, effective, responsive and well led were rated as Requires Improvement and caring was rated as Good. We also identified breaches of Regulation 11: need for consent, Regulation 12: safe care and treatment, Regulation 13: Safeguarding from abuse and improper treatment, Regulation 14: meeting nutritional and hydration needs and Regulation 17: good governance.

Avalon Ward was inspected but not rated in August 2020 in response to information of concern we received. At this inspection we identified a breach of Regulation 14: meeting nutritional and hydration needs.

Our rating of services improved. We rated them as good because:

- Staff had training in key skills, including therapeutic eating, and understood how to protect patients from abuse.
- Both wards were visibly clean and well maintained. Staff managed infection risk well.
- The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff assessed risks to patients and acted on them. They provided effective care and treatment, appropriate support around nutrition and hydration and offered emotional support when patients needed it.
- The service had systems and processes in place to safely administer and record medicines use. Medicines for use in emergencies were easily accessible to staff.

Our findings

- Staff worked well together for the benefit of patients, supported them to make decisions about their care and provided information to enable them to live healthier lives. They were focused on the needs of patients receiving care.
- Staff treated patients with compassion and respected their privacy and dignity. Staff provided emotional support to patients, families and carers.
- The services provided effective evidence based treatments for adults and young people with eating disorders based on national guidance and best practice.
- Leaders ran both wards well using reliable information systems. Staff felt respected, supported and valued. The staff had improved their engagement with patients, families and carers. All staff were committed to continually improving the service provided.

However:

- The building Wisteria Ward was located in was not suitable for good patient care and treatment. It was small and spaces had to be shared amongst staff and patients which at times impacted negatively on the patient's experience. The ward is due to move to improved accommodation in July 2022 and the trust invested £1.92m in the refurbishment.
- There were high vacancy rates for registered nurses and health care assistants on both wards. Wisteria Ward had not had a clinical psychologist in post since December 2021. The trust was actively recruiting into vacant posts and reviewed job descriptions to make them more attractive.
- Not all staff who needed to had completed basic life support training. Compliance was at 73% across the entire eating disorder service line. The trust had an action plan to address this shortfall including additional training sessions planned.
- Adult patients and young people and their carers / parents on both wards told us they were unsure how to make a complaint.
- Although improved overall since the last inspection visit, there were a few gaps in recording patients' physical observations in records we reviewed on Avalon Ward. Some staff on Wisteria Ward were not recording observation scores promptly and were holding this information in their heads until they could access a computer. There was a potential risk of inaccurate recording.

How we carried out the inspection

You can find further 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>.

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

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

Our findings

- Is it well led.

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

The team that inspected the service consisted of two inspectors, one inspection manager, a medicines inspector, one specialist advisor, with experience working in eating disorders service and an expert by experience, someone who has experience of care and treatment in an eating disorders service.

During the inspection visit, the inspection team:

- Observed how staff were caring for patients
- Attended multidisciplinary meetings on both wards
- Spoke with the managers of both wards
- Spoke with 24 staff members including consultant psychiatrists, junior doctors, clinical psychologists, advanced nurse practitioners, registered nurses and health care assistants.
- Spoke with four patients and eight carers, parents or relatives
- Looked at the quality of the environment on each ward.
- Reviewed nine patients care and treatment records
- Reviewed documents related to the running of the service

What people who use the service say

We spoke to four patients. We received a mixture of both positive and negative comments. All patients said they felt safe on the ward and the majority said they received good care and treatment from staff.

Patients told us that most staff were supportive and caring around mealtimes and although there were still occasional issues with catering, including incorrect portion sizes, this happened infrequently.

Carers of patients and young people told us their relative felt safe on the ward, that staff were polite and courteous and that both wards provided a positive environment.

However, patients on Wisteria Ward told us there was a lack of therapy available to them. Patients on both wards told us some non-permanent staff did not speak to them in a caring way.

Seven out of eight carers we spoke to told us communication with both wards was poor and inconsistent.

Is the service safe?

Good  

Our rating of safe improved. We rated it as good.

Our findings

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained.

Safety of the ward layout

Both ward environments were safe and well maintained. Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified. Staff carried out routine checks of the environment during each shift to identify any matters that needed to be addressed.

Wisteria Ward had several blind spots, meaning staff could not see patients at all times. Staff mitigated this risk with regular observations of patients and increased observations where a high level of risk was identified. Both wards had convex mirrors in place to help staff observe blind spots more clearly.

Avalon Ward complied with guidance on same sex inpatient accommodation. Male and female patients were on the same floor, but they had separate areas of the ward, which included two separate lounges.

Wisteria Ward had moved into temporary accommodation whilst their own ward was being refurbished and they had remained there for longer than originally anticipated. The temporary environment meant that when male patients were admitted they would have to pass by the female bedrooms in order to access their own. The ward mitigated this by having an additional staff member overnight to support patient safety.

At the last inspection, not all staff were aware of potential ligature points throughout the ward or where the ligature cutters were located. A ligature anchor point is an environmental feature or structure, to which patients could fix a ligature with the intention of harming themselves. During this visit we found that staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff managed ligature risks on both wards through keeping high risk areas locked unless a patient was accompanied by staff, through individual risk assessments and regular observations.

Both wards had specific ligature risk assessments. These were up to date for both wards and had action plans to address and mitigate any issues identified. The trust told us there were a number of ligature risks and actions they had formally accepted as 'tolerable (but naturally uncomfortable)' as there were plans to relocate both wards in 2022, as part of the estates' modernisation plan, with Wisteria Ward due to move in July 2022.

Both Avalon and Wisteria wards had alarm systems which allowed patients and staff to summon assistance if required.

Neither ward had a seclusion room.

Maintenance, cleanliness and infection control

Ward areas were clean and well maintained but space on Wisteria Ward was severely limited making it more difficult to care for patients safely.

Both wards were visibly clean. An external company was contracted to carry out the cleaning of the wards. Domestic staff were visible on the ward. Staff monitored the cleanliness of both wards on a regular basis. Monthly cleaning audits were undertaken jointly with the cleaning contractor and ward managers.

Our findings

Wisteria Ward was located over two floors, with the dining area located on a separate floor. There were not enough rooms in the ward area for members of the multidisciplinary team (MDT) to meet with patients on a one to one basis. Treatment rooms were small. For example, if a patient required to be restrained during nasogastric tube (NG) feeding it would be difficult to fit all staff and the patient in the room. Wisteria Ward is due to move to more appropriate accommodation in July 2022.

Both wards shared a garden area which was well maintained. Staff ensured the two patient cohorts, adults and children and young people, did not mix. Avalon Ward balcony area was available for patients to use. The garden area was well maintained with grass, table and benches.

Staff followed infection control policy, including handwashing. Hand hygiene audits for both wards showed high levels of compliance.

The most recent infection prevention and control (IPC) audit completed for both wards showed 100% compliance in all areas.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records showed that staff carried out checks on the equipment every day. FFP3 masks (a face and nose covering with the highest aerosol filtration percentage) were kept in the emergency bag for use by staff when carrying out chest compressions. Staff had been fit tested for an FFP3 mask and each ward had a designated ward tester.

Staff checked, maintained, and cleaned equipment. Stickers were applied to equipment to indicate when it had last been cleaned. Labels were attached to equipment showing the date on which it had been tested. All equipment had been tested and calibrated within the recommended timescale. The temperature of the medicines fridges was monitored regularly. Emergency medicines were checked daily.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm.

Nursing staff

Ward managers told us that there were enough nursing and support staff to keep patients safe. Managers regularly reviewed staffing levels and skills mix and sought support from the on-call manager if they were concerned about staffing levels.

There were vacancies for both registered mental health nurses (RMNs) and health care assistants (HCAs) on both wards. On Avalon Ward there were vacancies for five whole time equivalent (wte) band 5 nurses, and 5.6 wte HCAs. On Wisteria Ward there were vacancies for 2.6 wte band 5 nurses, 4.5 wte nursing associates and 7.5 wte HCAs

Both wards used bank and agency staff to cover shifts.

Between January and March 2022, 32% of RMN and 36% shifts of HCA were covered by bank or agency staff and a total of 10% of RMN and 4% of HCA shifts were unfilled. On Wisteria, in the same time period 34% of RMN and 60% of HCA shifts were covered by bank or agency staff and 5% of RMN and 2% of HCA shifts were unfilled.

Our findings

Whenever possible the wards tried to use bank or agency staff that were familiar with the ward and working with patients who had an eating disorder. There was always at least one registered nurse on each shift.

Workforce was on the risk registers as well as a standing agenda item on directorate and management meetings for both wards. Ward managers were meeting with the trust's nurse development team to support recruitment into vacant posts. The same team also arranged teaching sessions at local universities to highlight benefits of working in eating disorders. The South London Partnership (a sub-regional collaboration of five London boroughs working together to deliver healthcare initiatives) were also putting together a recruitment promotional video to address recruitment challenges.

The trust had completed a staffing establishment review for Wisteria Ward in January 2022 which proposed new nursing and multidisciplinary team establishment to meet the safe staffing requirements of the new 12-bed ward (due to open in July 2022) and supported the changes to the model of care and increased acuity. The plans included an additional nurse associate and band 3 posts, the addition of a housekeeper and an additional clinical psychologist and 0.5 wte family therapist post.

In the three-month period prior to the inspection visit, one patient on Wisteria Ward had required restraining for their NG feed, three times per day and there was one male patient at the time of the visit. Both had staffing implications and additional staff were added to each shift to support patient safety.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. For example, Avalon Ward had an induction video with patient input for new or bank staff.

Both wards had a number of staff that had left between March 2021 and March 2022. The turnover rate had risen from 23% to 32% on Wisteria Ward and reduced from 24% to 14% on Avalon Ward. These turnover rates had reduced since the last inspection and the trust had continued with their initiatives to improve retention rates. These included the bespoke and comprehensive induction programme and specialist training in therapeutic eating. Managers from both wards attended nursing recruitment open days.

Managers supported staff who needed time off for ill health. For example, one member of staff told us they had been supported to move between wards following time off due to stress, which they had found helpful.

The average rate of staff sickness (including COVID-19 related absences) between March 2021 and March 2022 was 10% on both wards.

The ward managers could adjust staffing levels according to the needs of the patients. For example, when Wisteria Ward admitted male patients additional staffing was required at night to keep young people safe.

Patients on both wards told us that they felt safe on the ward. However, some patients told us that occasionally their escorted leave would be delayed or cancelled due to the wards being short staffed. The wards operated a named nurse system where each patient had an identified member of nursing staff who was their key worker and a member of staff to support them each shift. Patients had regular one to one sessions with their named nurse. However, patients told us that they sometimes they did not have enough opportunities to speak to staff as they were too busy.

The service had enough staff on each shift to carry out any physical interventions safely.

Our findings

Staff shared key information to keep patients safe when handing over their care to others. Staff held handover meetings at the start of each shift. We observed a handover meeting on both wards and found that clear, helpful discussions were held regarding each patient's risks and needs.

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.

However, Wisteria Ward did not have any junior doctor cover and the trust was actively trying to recruit to this post. Another ward was providing junior doctor cover in the interim. The consultant told us that although they tried to be accommodating and flexible, they had to do some tasks to make up for the short fall in cover, such as bloods. The consultant psychiatrist was not a responsible clinician (an RC is an approved clinician who has overall responsibility in terms of the Mental Health Act 1983) and relied on their supervisor to approve section 17 leave and consent to treatment forms for patients who were detained under the Act.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff.

The programme was divided into groups; training one and two and covered 34 subjects including medicines management, nasogastric intubation and enteral feeding, mental health law, safeguarding adults and children and observation and intensive engagement.

Most staff had completed and kept up to date with their mandatory training. Avalon staff were 95% and 91% compliant with mandatory training one and two, respectively. Wisteria staff were 89% and 87% compliant with mandatory training one and two.

There were lower rates of compliance with medical emergency training, which was recorded as at 73% across both service lines in March 2022. This was related to a lack of adult basic life support (ABLS) training being available until February 2022. Although additional courses had been made available, it had been insufficient to meet the demand. There was an action plan with timescales in place to address this issue.

Managers monitored mandatory training and alerted staff when they needed to update their training. All training completed by staff was recorded. This enabled managers to see the training compliance for each staff member on a training dashboard. Managers discussed mandatory training compliance with staff during supervision and staff meetings.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed nine care and treatment records across both wards which all had a comprehensive risk assessment on admission and evidence that this was regularly updated following any changes in presentation or incidents.

Our findings

Staff used recognised risk assessment tools to assess risk of falls, malnutrition and refeeding syndrome (a serious and potentially fatal condition that can occur during the process of reintroducing food after malnutrition or starvation). Patient records showed patient risks recorded appropriately with clear management plans in place.

Patient records showed evidence of patients being assessed by a dietitian within two days of admission in accordance with national guidance. The quality and performance dashboard for each ward revealed risk assessments had been completed within 48 hours of admission 100% of the time, every month on both wards apart from October 2021 on Avalon Ward and January 2022 on Wisteria Ward.

Management of patient risk

Staff on both wards regularly assessed potential risks to patients' physical health by recording their observations and escalating concerns.

At the last comprehensive inspection in September 2019, we found that staff did not always correctly record patients' physical health observation scores and there were frequent gaps in recording observations. During this inspection, we found that overall improvements had been made. Staff checked patients' vital signs several times each day, using the National Early Warning Score (NEWS) on Avalon Ward and Paediatric Early Warning Score (PEWS) on Wisteria Ward. Both tools are used to improve the detection of and response to clinical deterioration in patients and are key elements of patient safety and improving patient outcomes.

Staff on both wards escalated concerns in accordance with guidance. Improvements were supported by the introduction of an electronic recording system to input NEWS scores on Avalon Ward.

Staff identified and responded to any changes in risks to, or posed by, patients. For example, the dietitian was involved in putting in place a refeeding meal plan for patients who required it. Another patient had risk management plans in place to monitor for falls and liver failure, both of which were related to low weight.

The trust had plans to incorporate PEWS scores into the electronic system although these were still being recorded manually at the time of our inspection. Most staff wrote scores down before recording them on the electronic patient record system later. This was not always done promptly as staff were reliant on when they could access a computer to do so. One staff member told us they memorised scores, but we were concerned this might increase the risk of inaccuracies in recording.

Staff followed procedures to minimise risks where they could not easily observe patients. This was challenging due to layout of both wards, but particularly on Wisteria Ward as several areas it was not possible to observe patients. However, staff managed risks either through increased observation levels, convex mirrors or locking certain environments, where necessary.

Both wards had also supported improvements through local audits undertaken by the team. Daily, weekly and monthly audits were undertaken. Although compliance was not at 100% there were fewer incidences where patient NEWS or PEWS scores had not been calculated or escalated in accordance with guidance.

On Avalon Ward we found it difficult to see where the gaps were despite observations being recorded on an electronic tablet. The nurse in charge would complete a daily NEWS audit to check all observations had been completed, but this had to be done manually. We looked at four records for the day after our inspection visit and found gaps in recording of physical health observations in all of them at least once for that date.

Our findings

On Wisteria Ward we noted patient observations had been missed once in the afternoon for four young people. This was raised with the deputy ward manager at the time who addressed it directly with the individual staff member responsible. All other patient observations were recorded correctly in all patient care records viewed.

Patient risk was discussed and updated daily in risk zoning meetings. The trust board had been advised of the inherent risks in both ward environments and were formally acceptable to them as 'tolerable' due to plans to relocate both wards to more suitable premises in the very near future.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Levels of restrictive interventions were low on both wards.

The trust's 'safety in motion' programme was part of the provider's strategy to reduce restrictive interventions. Staff on both wards were committed to using the least restrictive practice and this was evident in the low usage of restraint, seclusion and rapid tranquillisation across both wards.

Following the last inspection, we asked the trust to review the use of overly restrictive blanket restrictions on Wisteria Ward. Following this visit we found that Wisteria Ward had worked hard to reduce restrictive practice since our last inspection. In 2019, the ward closed for one month which allowed the whole staff group to undertake training on reducing restrictive practice and redesigning the patient pathway. The new pathway had reduced length of stay from 18 to 12 weeks.

Wisteria Ward had changed their approach to risk management. For example, changing their risk zoning procedure so that new admissions were not automatically zoned as red. Previously, new admissions were confined to bed rest, not allowed home visits and had all care and treatment in their room. This change in approach meant the care plan was personalised to the individual patient's risk and need.

Wisteria Ward had introduced electronic tablets owned by trust, for patient use. In 2021, a project piloted laptops so that young people could take part in lessons online, complete homework and keep in touch with friends and family. Unfortunately, because of concerns around patient confidentiality and social media, the ward manager put a pause on this project to ensure patient privacy and safety. However, they had plans to revisit this issue and see how other providers had managed inpatient access to smart phones to inform their approach in the future.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. For example, some patients required restraint for NG feeding to ensure their safety during this process.

Staff understood the Mental Capacity Act definition of restraint and worked within it. On Wisteria Ward, staff understood how to assess capacity in young people, including Gillick competence (a medical law term used to decide whether a child under 16 years of age is able to consent to their own medical treatment, without the need for parental permission or knowledge). Records showed that patients' capacity was assessed and recorded on a regular basis.

Our findings

Staff followed National Institute for Health and Care excellence (NICE) guidance when using rapid tranquilisation. Staff said this happened rarely on both wards (and not at all in the three months prior to our inspection visit) but if it did, they would check the patient's blood pressure, pulse, temperature and oxygen saturation levels after administering rapid tranquilisation. Patients were also assigned one-to-one observations from a member of staff after rapid tranquilisation.

Staff received training in de-escalation techniques and proactive preventive interventions, which included how to safely restrain patients with low body mass index. On both wards, staff provided patients one-to-one support after restraint to offer explanation and rationale and support de-escalation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. At the time of the inspection, staff on Avalon Ward were 98% compliant with safeguarding training in children and adults. Staff on Wisteria ward were 98% compliant with their training in safeguarding adults and 100% compliant with safeguarding children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, one patient informed staff they wanted to change their pronouns during their admission and nursing staff worked hard to ensure these were changed in their care planning and risk assessment documentation to reflect their wishes.

Staff knew how to recognise adults and children at risk of harm and worked with other agencies to protect them. Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. Patient care and treatment records showed evidence of appropriate safeguarding referrals being made, where necessary and follow up discussions in the MDT.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All information about a patient's care and treatment was stored on an electronic patient record.

Records were stored securely. Records could only be accessed by staff entering a username and confidential password.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff used an electronic system to prescribe and record the administration of medicines. They also used another electronic system to document patients' notes and care records.

Our findings

The clinical pharmacist was able to provide clinical input and advice. They could leave comments, advice or actions on patient's medicine administration records (MAR) which would then be actioned on the ward. We saw this system being used to good effect to meet the needs of patients and highlight where staff needed to monitor interactions between medicines.

Medicines were dispensed by the pharmacy department. Each ward held an amount of stock medicines to meet patients' needs, but anything that was unavailable could usually be delivered that same day. There was access to an out of hours pharmacy service for weekends and bank holidays.

Staff had access to emergency medicines and resuscitation equipment. This was checked every day.

The electronic system reminded staff when medicines were due and ensured that there was an appropriate gap between doses.

Consent to treatment documents were in place at the point of administration and adhered to for all patients in the service.

The wards were following national recommendations for the treatment of eating disorders. Medicines were used alongside other therapies to support treatment but never as the sole treatment. Treatment regimens included alterations for the physical health and weight/body surface area of the patients.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff and patients could access advice from a clinical pharmacist. The pharmacist visited at least every week and clinically screened patients' prescriptions.

There was a weekly meeting where patients' treatment including medicines were discussed by a multidisciplinary team of healthcare professionals. Patients were able to input into these meetings to ask for increase or reductions in dose or changes to prescribed medicines to meet their needs.

Staff completed medicines records accurately and kept them up to date.

Staff ensured that medicine records were accurate and up to date. Staff told us that sometimes the electronic MAR system would not allow them to make entries and so they would have to create a record in the patient's care notes. This had been escalated by the staff to the relevant team. If a dose was not administered for any reason, there was a clear record of this and the reason on the MAR.

Use of a 'when required' (PRN) medicines had an appropriate entry to explain why it was needed and if it had the desired outcome.

Staff stored and managed all medicines and prescribing documents safely.

Access to medicine storage areas and cupboards was appropriately restricted on each ward

Our findings

Medicines were stored appropriately so they remained safe and effective for use. The service used thermometers to monitor fridge and ambient room temperatures. We saw examples of appropriate action being taken when temperatures went outside of the recommended range to ensure the medicines continued to be safe and effective for use.

There was a single oxygen bottle not secured to the wall by an anchor point on Avalon Ward. We raised this at the time of the inspection, and it was arranged to have the bottle removed the same day.

Controlled drugs (medicines with additional storage requirements) were not held at the service but the correct storage and monitoring was in place and could be used when needed.

Medicines incidents were reported using an electronic system.

The service had a system to manage medicine safety alerts and would record actions taken.

Medicines audits were carried out by pharmacy department. Outcomes from these would be shared with the ward to help show where they were performing well and where improvements could be made around medicines optimisation.

There were systems in place to review medicine incidents and ensure that learning was shared with the other wards on site.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Rapid tranquilisation was not often used on the wards. Reviewing records from the previous three months we could find no administrations. We spoke to staff about the process and procedure that would be followed if it was needed and they were able to describe the process in line with national guidance and trust policy. When rapid tranquilisation was given, an incident form would be completed. Both staff and patients would also be debriefed to find ways to prevent its use in future.

Use of PRN medicines to manage agitation and aggression on the wards was low. Whenever possible, de-escalation would avoid using a PRN medicine. If a medicine was used, it was at the lowest available dose. Records were completed showing why it was needed and if it was successful in achieving the desired outcome.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Any medicines or treatment regimens that required additional monitoring would have these carried out within the required timeframe. At the time of the inspection the service had no patients on high dose anti-psychotic therapy and no one on medicines with special monitoring requirements.

Track record on safety

The service had a good track record on safety.

On Avalon Ward there was only one serious incident recorded in the 12 months prior to the inspection visit. A post incident review (PIR) was completed but it did not meet the threshold for reporting to NHS England. In the same time period, Wisteria Ward had only one incident that met the threshold to report to NHS England and six incidents were recorded as having a PIR completed.

Our findings

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. 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 patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff told us they were encouraged to report all incidents and near misses using an electronic incident reporting system in line with trust policy.

The service had reported no 'never' events on either ward in the 12 months prior to the inspection visit.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff we spoke to told us they had opportunities to debrief and felt supported by management when things went wrong. Senior managers looked after staff wellbeing and attended the ward when things went wrong.

The ward manager on Wisteria had changed how incidents were managed to support learning and a no blame culture. She had introduced the debrief wheel (a tool that goes through the incident phase by phase) to support staff to debrief following incidents.

Managers investigated incidents thoroughly. For example, when a set of keys went missing on Avalon Ward all keys needed to be replaced. Staff were reminded of the keys policy and procedure and to have keys attached to their person at all times.

Staff received feedback following incidents, both internal and external to the service. Business meeting minutes from both wards showed staff routinely discussed learning from incidents.

A recent incident on Wisteria Ward involved young people making social media accounts with staff personal pictures. Advice was given to staff about privacy settings on social media and staff were invited to contact senior nursing staff if needed. A debrief was held with the young people involved and their parents informed by email and invited to contact the ward if they wanted to discuss it further.

Staff met to discuss patient feedback and look at improvements to patient care. Business meeting minutes from both wards showed staff discussion on patient feedback. For example, reminding staff to be consistent when offering post-meal support to patients and ensuring named nurse allocations for the day were recorded on the whiteboard.

Managers shared learning with their staff about serious incidents that happened elsewhere. All staff received trust wide email bulletins that included information about serious incidents, and near misses elsewhere and learning from these.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good.

Our findings

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and most were personalised and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. All patients were assessed by a doctor on the day of admission. We saw evidence in all patient records of doctors completing comprehensive assessments which included reviewing the reasons for admission, a mental state examination, past medical and family history and a capacity assessment.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The physical examination was comprehensive. Staff recorded patients' vital signs.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Patient records showed patients on both wards had physical healthcare and treatment plans, naso-gastric (NG) feeding care plans, education and health promotion, safety and risk management plans as well as personal recovery goals.

Care plans on Avalon Ward showed good evidence of patient involvement in care planning. For example, collaborative risk care plans were completed in the patients' own words. However, care plans on Wisteria were more generic, with less evidence of direct patient involvement.

Staff regularly reviewed and updated care plans when patients' needs changed. For example, one NG care plan stated the patient wanted to avoid the NG feed and the plan had stages for how they could achieve this. The person had agreed to remain seated during the NG feeding process until meal replacements were safe to introduce.

Most care plans we reviewed were personalised, holistic and recovery orientated. For example, one patient had developed their own personal recovery goals which included eating one portion at lunch and trying to reduce their obsessive-compulsive disorder rituals. Another patient had goals related to being comfortable eating with other people.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients 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. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Patients on both wards had access to a range of different groups and activities. For example, groups run by the ward dietician or occupational therapist. Patients on Avalon Ward had access to psychology and family therapy input.

However, Wisteria Ward did not have a full MDT and there was currently no psychologist which meant patients had no access to psychology sessions. Patients and carers said this was essential to their care and treatment.

The recent staffing establishment review had reviewed the job description and created an additional post to support with recruitment. The trust had developed a recruitment plan which included an initial focus on the nursing establishment, recruiting to the housekeeper role in line with the successful format Avalon Ward had used for the same role and implementing changes to the job descriptions for the psychology posts to make them more attractive to potential candidates.

Our findings

The doctors considered NICE guidelines when prescribing medicines. Treatments for eating disorders were based on national guidance which included the management of really sick patients with anorexia nervosa (MARSIPAN) and junior MARSIPAN (for children and young people).

Staff identified patients' physical health needs and recorded them in their care plans. Patients had their physical health assessed regularly throughout their admission. Physical health checks were comprehensive. Records showed all patients' physical health risks were assessed on admission by a doctor and included an assessment of the risk of refeeding syndrome and malnutrition.

Staff made sure patients had access to physical health care, including specialists as required. Patient records showed appropriate referrals being made. For example, one patient was referred to an optician for blurred vision and another patient had been supported to attend a hospital appointment.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. At the last inspection we were concerned there was a lack of dietitian input onto both wards. At the current inspection we found that both wards had dietitian cover. Avalon Ward had a dietitian four and a half days per week and Wisteria Ward for three days per week. The trust has recently increased this to 1.1 wte for Avalon Ward and 1 wte for Wisteria Ward as part of their planned future provision. Records showed dietitian input into care and meal planning for all patients. Both wards had dietitian led groups and patients told us they could meet with the dietitian once per week to discuss their individual needs.

Patients on both wards had a formal assessment of nutritional status completed by a dietitian. Four out of five patient records showed this had been completed within two days of admission as per quality network for inpatient CAMHS – eating disorder (QNIC-ED) guidance. One patient had a nutritional assessment completed within three days of admission.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, Wisteria Ward had a 'nourish to flourish' group run by the dietitian where patients could discuss nutrition and learn how to eat healthily.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff on Avalon Ward completed health of the nation outcome scales (HoNOS). This covers 12 health and social domains and enables clinicians to build a picture over time of patient responses to interventions. Staff completed this at the start and end of patients' treatment to measure progress.

Staff on Wisteria Ward used SMART (specific, measurable, achievable, relevant and time-bound) objectives to assess patient outcomes. These were recovery orientated goals young people developed themselves. For example, to be comfortable eating with other people present.

Staff used technology to support patients. Both wards had supported patients to maintain contact with friends and family through video calls on trust electronic tablets during the COVID-19 pandemic.

Both wards had quality improvement initiatives staff were involved with. Avalon Ward had implemented a project aimed at improving staff culture in January 2021. This included thematic analysis of staff feedback and identified actions put in place. For example, the introduction of therapeutic eating simulation sessions for staff to reflect on what did and did not go well when supporting patients during mealtimes.

Our findings

Following the last inspection, we asked the trust to ensure that systems in place to assess, monitor and improve the quality of service in Wisteria Ward were effective. During this inspection we found that managers on both wards used results from audits to make improvements. The trust adopted an 'Always Ready' approach to audits and used a dashboard to track results and progress on a variety of measures including hand hygiene, infection control and consent to treatment.

Care plans were regularly audited to ensure there was an up-to-date crisis plan, risk assessment and formulation, physical health plan and whether the patient was involved in care planning. Audits were colour coded to indicate if action was required and had plans to address any issues identified.

Skilled staff to deliver care

The ward teams included some of the specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Avalon Ward had access to a range of specialists to meet the needs of the patients on the ward. For example, the clinical psychologist provided CBT (cognitive behavioural therapy) and MANTRA (Maudsley model of anorexia nervosa treatment for adults) and the consultant psychiatrist was trained in psychodynamic therapy.

However, Wisteria Ward had several vacancies across the multidisciplinary team (MDT) which included a social worker, occupational therapist, housekeeper, speciality doctor and psychology.

The family therapist and consultant psychiatrist were able to offer some therapy sessions to young people and their families. Locums were filling some roles but at the time of our inspection there had been no psychologist since December 2021 and this was impacting on patients who told us they had no or limited access to psychological therapies during admission.

The trust had worked on a staffing plan for the ward which included reviewing the job descriptions in order to make them more attractive to applicants. The psychology provision had been increased to two wte posts, but these were unfilled at the time of the inspection.

The trust told us recruitment was a challenge because of a national shortage of qualified clinical psychologists and the working environment in the temporary accommodation. It was hoped this would improve when the ward moved premises in the coming weeks.

Recruitment was ongoing and the trust confirmed there were suitable applicants for all the vacant psychology posts on Wisteria Ward. A locum eating disorder therapist had been employed to provide specialist therapeutic input for the young people in the interim period until the vacancies had been filled by permanent staff.

The young people did have access to therapeutic groups on a weekly basis. For example a dialectical behavioural therapy skills group (DBT is a type of talking therapy). The family therapist also met with patients and their families weekly and the consultant psychiatrist planned to introduce 'The Tree of Life' sessions with the young people (a counselling approach to working with young people who have experienced trauma).

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Our findings

Following the last inspection, we asked the trust to ensure staff completed training in therapeutic eating and maintained training records of who had completed this. During this inspection we found that all permanent members of staff on Avalon Ward had completed specialist training in therapeutic eating. A senior nurse also supported staff with weekly simulations where staff could bring issues for discussion around supporting patients during and post meal.

The majority of staff on Wisteria Ward had completed training in therapeutic eating and the ward manager said two deputy ward managers had been given additional time to develop a bespoke therapeutic eating training package for young people.

Managers gave each new member of staff a full induction before they started work. On Avalon Ward all new and established staff had taken part in a three-day induction programme. Staff had provided positive feedback saying that they felt more prepared for their role as a result of this. Avalon Ward had also put together an induction video for new and bank or agency staff, which was coproduced with patients.

Managers supported staff through regular, constructive appraisals of their work. Ninety-one per cent of staff on Avalon Ward and 94% of staff on Wisteria Ward had an up to date appraisal.

Managers supported permanent, non-medical staff through regular, constructive clinical supervision of their work. Nursing staff had monthly supervision and senior nurses supervised their junior colleagues providing them with skills development and learning.

Over the last 12 months, 95% of clinical staff on Avalon Ward had supervision monthly apart from August 2021 when it was 92% and January 2022 when it was 83%.

However, in the same time period on Wisteria Ward, there were lower rates on monthly supervision. We saw evidence in the business meeting minutes that the ward manager had made efforts to improve this and since December 2021, 95% of staff on Wisteria Ward had monthly supervision with 100% in February 2022.

Managers made sure staff were supported and encouraged to attend regular team meetings or handed over information to those who could not attend. Minutes from these meetings showed discussion around training, learning from incidents and patient feedback. The trust emailed all clinical staff a bulletin which included learning, training and other information relevant to the wider trust.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. In addition to introducing therapeutic eating training for all permanent staff on both wards, other training opportunities had been made available. For example, the ward manager and another senior nurse on Avalon Ward were completing accredited training in autism sponsored by NHS England.

The Wisteria Ward manager had been offered leadership training and tier four training in autism. Nursing staff told us they were supported to attend courses and seminars they were interested in.

Managers made sure staff received any specialist training for their role. The medical staff delivered bite sized training on a range of topics including physical health, diabetes and risks of refeeding syndrome. Ten staff on Avalon had also completed eating disorder training run by South London and Maudsley NHS Trust with the aim of all staff to have completed this by 2025.

Our findings

Managers recognised poor performance and dealt with it promptly and effectively. Managers took appropriate action and followed the trust disciplinary policy as required.

Ward managers had worked hard since the last inspection to change the culture on both wards. On Wisteria Ward, the manager had introduced new processes in incident management to develop a no blame, learning culture as well as developing the nursing staff role to support staff build skills and confidence.

Both wards emphasised trust values to staff and supported staff to make changes where needed through supervision or additional training.

Avalon Ward had recently started a project to screen all patients for autistic spectrum disorder (ASD) using AQ-10 (the autism spectrum quotient tool for use with adults to help identify whether someone should be referred for a comprehensive autism assessment).

Patients reported that most staff supported them appropriately during and after mealtimes and that they had found this a helpful part of their care and treatment.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Both wards held weekly ward rounds and daily zoning meetings where patients were discussed, and risk assessments and care plans were updated. Patients could attend ward rounds as well as their care programme approach (CPA) review meetings, which family would be invited to.

Staff made sure they shared information about patients and any changes in their care, including during handover meetings. Daily zoning meetings were well attended by the MDT on both wards, had clear structure and a good handover of patient information, which included any update on risks and physical health needs.

Ward teams had effective working relationships with other teams in the organisation. Wisteria Ward had recently worked to improve relations between themselves and the community teams through regular meetings where barriers to good communication and other issues were discussed and solutions identified. This resulted in admission and discharge being smoother for the patients and staff.

Doctors worked closely with their acute medical colleagues to support with patients' physical healthcare. For example, the staff grade doctor on Wisteria Ward met regularly with paediatric colleagues from the local acute trust to discuss any patient concerns they had.

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 patients' 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. 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.

Our findings

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. We saw posters on both wards displaying information about patient rights (including the right of informal patients to ask to leave), access to advocacy and advocates visited each ward at once per week to meet with patients.

Records showed that where patients were detained under the Mental Health Act, staff explained their rights in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Although some patients told us leave could be delayed sometimes due to staffing challenges, it was usually rescheduled for the same day.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Managers made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings as part of the trust's 'Always Ready' audit processes. These included action plans to address any gaps in recording.

However, although we saw information displayed on Avalon Ward advising informal patients that they could leave, we did not see this information displayed on Wisteria Ward.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and could access advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed capacity was assessed by measuring a patient's ability to understand, retain and weigh up information before determining that they lacked capacity.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Records showed capacity to consent assessed and clearly recorded including whether a young person was Gillick competent.

None of the young people on Wisteria Ward who were on a naso-gastic feed were informal, all were detained under the Mental Health Act.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. For example, one young person assessed as lacking capacity had still been involved in developing recovery goals that were personal to them and their needs and interests.

Our findings

Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

During the last inspection patients told us that staff were not always polite, respectful or approachable. This time, patients said most staff treated them kindly and with respect. They told us they could speak to their key nurse and found them supportive. One patient told us staff could be really helpful and made time for patients to talk. Another patient described nursing staff as friendly and welcoming particularly when they were first admitted.

We observed positive interactions between patients and staff on both wards. For example, staff sitting near patients undertaking observations were actively engaged with them discussing different topics.

Another staff member showed compassion and care when walking by a patient bedroom and, on hearing them crying, stopped, knocked on the door and asked if she could come in. The patient agreed and the staff went in and sat with her.

However, three out of four patients we spoke to said it was harder to get on with some nursing staff. For example, bank staff were unfamiliar with the patient's individual care and treatment needs. One patient said they had felt like they were a burden to some staff, and another said some bank staff did not know their name when checking their observations and used their room number instead, which felt dehumanising.

Staff directed patients to other services and supported them to access those services if they needed help. For example, we saw posters displaying patient information on how to access spiritual support, if needed.

Staff understood and respected the individual needs of each patient. They were able to tell us about the individual patients and their risks and needs as well as the current care and treatment plans.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke to told us this has improved since our last inspection and they felt supported by managers to speak up about any concerns they had.

Staff followed trust policy to keep patient information confidential. For example, patients were reminded to keep their copies of their care plans in the bedrooms.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Our findings

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Patients told us that they had been orientated to the ward by staff when they were admitted. However, some patients told us that they had not been told how mealtimes worked and were reliant on other patients to let them know about this.

Staff involved patients and gave them access to their care plans and risk assessments. Patient records showed evidence of patient involvement. For example, young people on Wisteria Ward were encouraged to develop personal recovery SMART objectives. Records showed collaborative risk assessments and care plans documented in the patient's own words.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. For example, hearing loop information and posters with information on supporting communication needs for staff was displayed, such as how to access information in easy read or large font formats.

Staff involved patients in decisions about the service, when appropriate. For example, patients had been involved in meeting with the catering contractor to provide feedback on meal provision.

Patients could give feedback on the service and staff supported them to do this. We saw examples of patient feedback given through the trust's feedback live system, which was collated and reviewed. Both wards held regular, weekly community meetings where patients could discuss issues and give feedback. Staff responded to this and patients were updated. Minutes from these meetings were displayed on ward notice boards.

Staff made sure patients could access advocacy services. We saw posters on patient rights and advocacy displayed on both wards. Advocates also visited the wards on a weekly basis to speak to patients.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Records showed regular contact between the ward and carers, either over the phone or through attendance at review meetings and ward rounds.

Parents of young people were updated by email following ward rounds each week. For example, one parent was sent an email about a change to their child's medication with reasons for this change.

Carers could be signposted to carer groups or organisations, or referred for a carers' assessment, if needed. Carers were also discussed in the MDT and handover. Both wards held a carers group fortnightly virtually and we saw evidence of carers attending this in patient records.

Carers told us they were able to visit the wards with some restrictions in place due to the pandemic, such as lateral flow testing and wearing masks.

Carers said most staff were pleasant, friendly and knowledgeable. They told us they were invited to attend review meetings and were given updates on their relatives' care and treatment, where consent had been provided to do so.

However, carers of young people on Wisteria Ward were concerned about the lack of psychology input and told us they felt this was an essential part of their relative's care and treatment.

Our findings

Seven out of eight carers of patients on both wards said there was inconsistent communication with the wards and could be confusing. For example, around visiting procedures. They told us there was a lot of bank and agency nursing staff who were less familiar with their relatives' care and treatment plans.

One carer had complained about a lack of communication on Avalon Ward and although things had improved, they felt the purpose of meetings was not made clear, which meant expectations were not met.

Both ward managers independently highlighted communication with carers as an issue that they were actively working to improve. For example, Wisteria Ward had implemented several measures to improve communication with parents and carers such as the allocated key nurse sending a letter of introduction to parents with key contacts and other useful information prior to admission.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

Managers tried to make sure bed occupancy did not usually go above 85%. In the three months prior to the inspection visit Wisteria had an average bed occupancy of 86% and Avalon had an average of 78%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. This was done with patients and carers at weekly MDT meetings and regular review meetings. The ward invited members of the community team, where appropriate, to these meetings to ensure the smooth coordination of a patient's care and treatment.

Managers and staff worked to make sure they did not discharge patients before they were ready. For example, the quality improvement work undertaken with community colleagues which meant discharges were well planned and were discussed throughout the patient's admission.

On Wisteria Ward this discharge process had been complicated by managing the young person and their family's expectations of the new patient pathway, which had reduced patients' length of stay. Some parents of young people felt their child needed to be in hospital for longer.

When patients went on leave there was always a bed available when they returned.

Staff did not move or discharge patients at night or very early in the morning.

Our findings

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

There had been no delayed transfers of care for either ward for the three-month period prior to our inspection visit.

Patients did not have to stay in hospital when they were well enough to leave. Both wards worked closely with patients, carers, their families and community-based colleagues throughout the person's admission to support timely, safe and effective discharges. Care coordinators were involved in MDTs and review meetings to support progress and facilitate discharge.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Wisteria Ward had completed a quality improvement project with the community team involving six sessions where staff from inpatient and community services met to discuss their roles and expectations. The ward manager said this had improved the safety and effectiveness of the discharge process for young people.

Staff supported patients when they were referred or transferred between services. For example, patients and carers would be sent a welcome letter with useful information prior to admission.

The service followed national standards for transfer. Electronic patient records included a shared, single language for IT systems designed to make exchanging information between systems easier, safer and more accurate.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of Avalon Ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. However, the design and layout of Wisteria Ward, which was in temporary accommodation, was not fit for purpose.

Each patient had their own bedroom, which they could personalise.

Patients were able to store some valuables in the nurse's office.

Staff used a full range of rooms and equipment to support treatment and care. However, due to the environment Wisteria Ward staff were limited by the space and this made it difficult to carry out care and treatment effectively. For example, therapists found it difficult to find an available room to meet with patients and their families. The naso-gastic feed and clinic rooms were very small, which meant providing effective treatment was challenging.

The service had quiet areas and a room where patients could meet with visitors in private. However, on Wisteria Ward when visits happened there was less space for therapeutic activities due to the limited availability of private rooms overall. Wisteria Ward is due to return to a newly refurbished ward, with more space, in July 2022.

Patients could make phone calls in private.

The service had an outside space that patients could access easily. Both wards shared a garden space and staff ensured this was not accessed by separate patient cohorts (adults and children) at the same time.

Our findings

At the last inspection we were concerned that there was not a wide variety of good quality food available for patients on both wards and this was the subject of many patient complaints. Since this time both wards had worked hard to address this. Both wards met regular staff and patient meetings with the catering contractor to discuss issues and concerns.

Both wards had a housekeeper as part of their staffing complement although Wisteria Ward had not yet recruited to this role. The housekeeper was responsible for checking meals delivered against orders, heating and serving up the food to patients and it was hoped this would improve the process further.

Patients on both wards said there were fewer issues with food provision than before.

The trust collated PLACE (patient-led assessments of the care environment) data. The 2022 data for Avalon and Wisteria Wards showed both scored 99% satisfaction with cleanliness, 100% and 95% respectively for privacy and 98% and 96% respectively for condition, appearance and maintenance of the environment. PLACE data for the Springfield University Hospital site overall recorded a score of 96% for ward food.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients. Both wards had activity timetables, which included various groups including those run by the occupational therapist and dietitian.

Activities on Avalon Ward included a games group, medical education group and an open art space. During term time the young people on Wisteria Ward were expected to attend education classes from Monday to Friday.

Wisteria Ward had several outings and patients told us they had recently been to an escape room, which they had enjoyed. Both wards had volunteer activities coordinators who provided things to do at the weekend.

Staff helped patients to stay in contact with families and carers. During the pandemic patients could contact friends and family using a trust electronic tablet. Both wards were now accepting visitors through a booking system.

Meeting the needs of all people who use the service

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

The service supported patients with disabilities including with communication or other specific needs. Both wards had disabled access toilets and lifts. Ward notice boards included posters on hearing loops and encouraging patients to speak to staff if they had communication needs and required information in easy read or large font formats.

Transgender patients were supported appropriately and their preferred pronouns used in care planning and treatment documentation.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Wards had information displayed on patient rights, independent advocacy, complaints procedures and CQC contact information. Independent advocates visited both wards in person on a weekly basis.

Our findings

Managers made sure staff and patients could get help from interpreters or British sign language interpreters when needed. Information leaflets in other languages could be requested via the trust's communication team, if needed. Staff had access to an external provider for interpreting and translation services when required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients on both wards could access vegan, vegetarian, kosher and halal food, if required. Young people on Wisteria Ward were allowed to nominate three foods they disliked at any one time which were separate to any other dietary requirements for religious, moral or allergy reasons.

We found the wards had increased menu choices available to patients and provided a greater degree of flexibility in changing menu and snack choices available. However, limited space on Wisteria Ward meant young people were unable to cook or bake with the occupational therapist. The new premises the ward was moving to would contain an activities of daily living kitchen for the use of patients and staff.

Patients had access to spiritual, religious and cultural support. We saw posters with contact details for spiritual support through the spiritual care team displayed on the wards.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The service clearly displayed information about how to raise a concern. Both wards had details of how to make a complaint on patient information notice boards. Patients on Avalon Ward told us they would feel comfortable making a complaint or raising an issue in the community meeting. However, patients we spoke to on Wisteria Ward were unsure how to complain.

Staff understood the policy on complaints and how they were managed. Complaints were acknowledged and patients received feedback from managers after the investigation was concluded.

Managers investigated complaints and identified themes. Ward managers would speak to patients directly if they complained to try to resolve the issue.

Patients received feedback from managers after the investigation into their complaint. Where a patient or a carer made a complaint, this would be dealt with in line with trust policy and a response given in writing within a certain timeframe. Over the last 12 months, Wisteria Ward had no complaints and Avalon Ward had nine. All were responded to within the 25-day period. Complaint themes included dissatisfaction with food provision and nursing care provided.

We reviewed three separate complaints which showed complaints were taken seriously, investigated thoroughly and an explanation and apology given when things went wrong.

Patient concerns and complaints were a standing agenda item in staff business meetings and included discussing changes that needed to be made as a result. Business meeting minutes from both wards showed that complaints had been discussed with staff.

Patients on both wards told us the main issue they had complained about was meal provision. Both wards had set up regular meetings with the catering department and patients to discuss issues as they came up to support finding solutions quicker. As a result, there were fewer complaints about the food provided.

Our findings

Community meeting minutes from both wards showed evidence of changes made as a result of patient feedback. For example, on Wisteria Ward staff had contacted the catering department to update the options for snacks, sandwiches and desserts.

The service used compliments to learn, celebrate success and improve the quality of care. Wisteria Ward had a noticeboard that displayed anonymised patient and carer thank you cards. Compliments and positive feedback were also discussed in the ward business and operational meetings. Wisteria Ward had recently been nominated for the 'best clinical team of the year' at the 2021 trust awards.

However, most carers we spoke to were unsure how to make a complaint should they wish to.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff said leaders and managers in the service were supportive and spoke highly of them. Managers in both wards were aware of the key challenges and risks and were open in sharing them. They were clear about how staff were working to provide high quality care that was safe, whilst striving for continued improvement in challenging circumstances.

Both ward managers were visible on both wards, interacting with patients and staff. They attended multidisciplinary team meetings and handovers regularly. The leadership teams had worked hard to support and develop good relationships and improve the culture on both wards since the last inspection.

Vision and strategy

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

Staff understood the trust's vision and strategy. This included the estates modernisation programme which involved both wards moving into new premises in 2022. Avalon Ward would be co-located with the community and day unit team in future. Wisteria Ward would be located in the existing hospital building that was being repurposed.

Patients on both wards said they felt safe and that most staff were caring, kind and made time to listen to them.

Wisteria Ward had redesigned its patient pathway since the last inspection reducing length of stay from an average of 18 months to 12 weeks.

The trust had invested £1.92m in the Wisteria Ward refurbishment in order to increase bed capacity, improve ward layout to support recovery, create family areas to support cooking and group sessions, and upgrade the facilities throughout to improve security and safety. The refurbishment has been delayed by building supply issues which meant the move had been put back from April to July 2022.

Our findings

Managers embodied the trust's values in their approach to their work, working openly and collaboratively with the staff team to support culture change, better working lives and improve patient experience on both wards. The trust values were on display in the ward for staff and patients to see.

Culture

Staff felt respected, supported and valued. They said the trust provided opportunities for development and career progression. They could raise any concerns without fear.

Most staff felt positive and were proud to work for the trust and their team. The 2021 trust wide staff survey (with a 58% response rate) showed that 78% of respondents felt their immediate manager valued their work and 76% said there were frequent opportunities for them to show initiative in their role.

The manager on Wisteria Ward had introduced measures to redevelop the role of the key nurse with increased responsibilities, which had improved culture, morale and performance. There was clear evidence of actions already taken and those planned to address concerns at different levels across the service.

Career development was supported. Staff supervision on both wards included conversations about development goals. Staff said managers supported them to identify professional development opportunities. For example, some staff were attending an NHS England accredited course on autism.

Staff said they could raise concerns with their colleagues and managers without fear of reprisals. They said their views would be listened to and acted upon. Staff were aware of and knew how to use the whistleblowing process and about the role of the Freedom to Speak Up Guardian.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Leaders had developed and operated effective governance processes. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of both wards.

Managers and staff were clear on the risks they faced and when they were missing targets and were working hard to make improvements and mitigate any risks. Performance and risks were routinely discussed in business and nursing meetings.

There were effective governance processes in place to improve and discuss care which covered areas including risk, clinical audit results, referrals and discharges.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Service level risks reflected those recognised by staff and risk registers had clear action plans to mitigate any risks identified. The risk registers reflected the key challenges and risks faced by both wards.

Our findings

Both wards had risk registers including action plans and progress updates on each item. For example, Avalon Ward was addressing ward culture among staff to bring it in line with trust values to improve patient experience. Risks identified on Wisteria included the recruitment of a psychologist and the ward environment.

Leaders and managers had oversight of the risks both wards faced and demonstrated a clear understanding of how to improve performance.

Managers monitored performance indicators including serious incidents, infection control, outcome measures and the use of agency staff. Members of the MDT took part in audits which were reported on a quarterly basis with action plans and recommendations to reduce any shortfalls. Performance indicators were discussed at management and staff business meetings to monitor progress and identify any barriers to mitigating issues identified.

Information management

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The electronic patient record system was effective for documenting patients' needs, care planning, monitoring mental and physical health as well as recording and updating risk assessments. Patient records were kept confidential.

We reviewed minutes of directorate and management meetings, performance and quality reports and dashboard data for the 12 months prior to the inspection and found there was clear recording of information, updates and actions.

Both wards made notifications to external bodies as appropriate including statutory notifications to CQC and local authorities.

Engagement

Managers engaged actively 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. Patients and carers had opportunities to give feedback about the service.

Managers actively engaged with other local health and social care providers to ensure that an integrated health and care system was commissioned to meet the needs of the local population.

Documents and meeting minutes demonstrated work across south London to ensure system wide participation in meetings, looking at service redesign to ensure the needs of the local population were met and that care continued to improve.

The trust collected feedback from patients with actions taken immediately or feedback given in a timely manner. Patients could provide feedback through face to face discussions, community meetings chaired by someone with lived experience or anonymously through the trust's feedback live system.

Both wards worked closely with the patient advocacy and liaison service to gain feedback and improve performance.

Learning, continuous improvement and innovation

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities

Our findings

Ward managers had access to information on their team's performance collated through clinical audits, which were displayed on a dashboard. This included information on completion of patient risk assessments, care plans, physical health observations and infection control measures.

Both wards had audit schedules which involved members of the multidisciplinary team taking responsibility for specific areas. Audit outcomes were fed into a monthly dashboard and regular performance reports were produced, scrutinised and acted upon.

Both wards had embraced quality improvement (QI) initiatives to address risks identified and improve overall performance and staff at all levels were involved in these. For example, Avalon Ward had a framework for improvement with issues, themes, core drivers and improvement activities clearly laid out. The latter included dates of future sessions with all staff and patients to be involved directly.

We saw posters advertising opportunities for patients to take part in research and QI projects displayed on the ward.

Leaders looked to other organisations to support learning and development in order to improve performance. For example, sharing specialist training from a local independent health provider on eating disorders and meeting with another NHS trust to discuss naso-gastric feeding.

Our findings

Areas for improvement

Action the trust Should take to improve:

- The trust should ensure that priority is given to Wisteria Ward moving into the new premises as soon as possible.
- The trust should ensure that staff promptly and accurately record patients' vital signs in the electronic patient record system.
- The trust should ensure all relevant staff are up to date with life support training
- The trust should ensure continued focus on recruitment to vacant posts, including the clinical psychologist post on Wisteria.
- The trust should ensure that adults and young people on both wards and their carers have information on how to complain

Our inspection team

The team that inspected the service consisted of two inspectors, one inspection manager, a medicines inspector, one specialist advisor, with experience working in eating disorders service and an expert by experience, someone who has experience of care and treatment in an eating disorders service.