Riverdale Grange Clinic

Quality Report

93 Riverdale Road
Ranmoor
Sheffield
South Yorkshire
S10 3FE
Tel: 0114 230 2140
Website: www.riverdalegrange.co.uk

Date of inspection visit: 9th & 10th May 2016
Date of publication: 21/09/2016

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Riverdale Grange Clinic as requires improvement because:

- As of May 2016, average compliance for mandatory training for the child and adolescent unit was 74%. Average compliance for mandatory training on the adult unit was 77%.
- The service had high vacancy rates for qualified nurses and nursing assistants. The child and adolescent unit had a staff turnover rate of 45% and the adult unit had a staff turnover rate of 23%. This had impacted on training compliance.
- Not all staff working on both the adult unit and the children's unit were trained in safeguarding level three.
- Compliance rates with basic life support training was 46% for all non-clinical staff and 50% for clinical staff on the child and adolescent unit. Compliance rates for the adult unit were not clear from the training matrix provided.
- The Mental Health Act policy was not dated, nor did it have a date for review listed. The changes in the code of practice which came into place in April 2015 had not been incorporated into the policy.
- Checks to ensure directors meet the fit and proper person regulation had not been completed.

However

- The provider ensured that there were sufficient staff available. A professional judgement tool was used to calculate staffing establishments. Staffing levels were adjusted to ensure safety at all times and took into account bed occupancy, new admissions and periods of one to one observations.
- We saw that physical health monitoring was in place and carried out in accordance with care plans written for the individual. Physical health checks and monitoring were overseen by two general practitioners who visited the units weekly or daily during the first 72 hours of any admission.
- Care planning showed the involvement of patients, family members where appropriate and members of the multidisciplinary team. They covered all aspects of care and were reviewed on a regular basis. All patients were given copies of their care plan.
- There was a wide range of professionals within the multidisciplinary team. These professions are recommended within guidance issued by the National Institute for Health and Care Excellence.
- Both ward managers felt supported in their roles and had the autonomy to make decisions in the absence of the service managers. The ward managers also participated in the on call rota.
- Both units were participating in the Royal College of Psychiatrists' accreditation scheme through which good practice and high quality care are recognised and services are supported to address any areas for improvement

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorders services	Requires improvement 	

Summary of findings

Contents

Requires improvement

Riverdale Grange Clinic

Services we looked at:
Specialist eating disorders services

Summary of this inspection

Background to Riverdale Grange Clinic

Riverdale Grange Clinic was an independent hospital providing treatment and care to people with eating disorders. The hospital had 18 inpatient beds in two separate units; one treating up to nine adult patients and the other treating up to nine young people. In addition the hospital could provide services to day patients and outpatients, although this was not happening at the time of our inspection. Riverdale Grange Clinic was a converted and significantly extended building contained within its own grounds in the south west of Sheffield.

The hospital had two registered managers, one primarily for the child and adolescent mental health unit and one for the adult unit, although they worked on a job share basis and covered for each other during periods of leave. There was also a controlled drugs accountable officer in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about the running of the service.

Riverdale Grange Clinic has been registered with the CQC since 19 January 2011. It is registered to carry out three regulated activities; (1) treatment of disease, disorder or injury; (2) assessment or medical treatment for persons detained under the Mental Health Act 1983(child and adolescent unit only); and (3) diagnostic and screening procedures.

The hospital has been inspected by the CQC on four previous occasions. The last inspection on 22 May 2013 found no breaches of the 2010 regulations.

Our inspection team

Team leader: Janet Dodsworth, Care Quality Commission

The team that inspected the service comprised of: four CQC inspectors, a CQC pharmacist, a registered nurse, a mental health Act reviewer and an expert by experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme

How we carried out this inspection

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

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

Before the inspection visit the inspection team:

- Reviewed information that we held about the location.
- Spoke with the commissioners of the service.
- Attended a carers group and spoke with three carers.
- Sought feedback from 23 staff members who attended focus groups: seven support workers, five registered nurses, one assistant psychologist and ten other staff from administration, housekeeping and maintenance.

During the inspection visit the inspection team:

- Undertook a tour of the hospital and looked at the layout of the ward and cleanliness of the environment.
- Spoke with 13 patients who were using the service.

Summary of this inspection

- Spoke with another two carers by phone.
- Spoke with two service managers, two ward managers and two consultant psychiatrists.
- Spoke with 18 other staff members; four registered nurses, four support workers, a family therapist, a clinical psychologist, a dietician, an occupational therapist, a cognitive behavioural therapist, the chef, a housekeeper, human resources manager and mental health act administrator and a teacher.
- Looked at 15 care and treatment records.
- Reviewed three staff personnel files.
- Collected feedback from eight patients using comment cards;
- Attended and observed a multidisciplinary team meeting, two community meetings, two nursing hand-over meetings, a clinical team meeting, a snack session and a patient activity session.
- Carried out a check of the medication management.
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Relatives told us the hospital is always clean and tidy when they visit. Visiting is encouraged but relatives are asked to avoid therapy or education times. They felt well supported by staff and felt they had a good understanding of eating disorders and the possible difficulties that might arise when their relatives were on leave from the hospital. One carer told us they had seen their family member make significant progress and commented on how the staff were on top of every little sign of eating disorder. They said staff had listened to them and kept them fully informed at all times. They had also received helpful advice and tips on how to handle difficult issues at home.

Young people on the child and adolescent unit told us they felt safe on the unit. One young person told us that the staff help them by checking their bags and room to ensure they do not have items they could use to harm themselves. They commented that the atmosphere is so nice, staff and patients get on well.

Adult patients commented that staff always talk through actions and treatments and explain things before taking any action. They felt they had a good balance between treatments, therapy and group activity which made a big difference to their recovery. Patients did make comment that when they are discharged, the community follow up is not available and felt there was a gap in the ongoing support from community teams. We received five comment cards which made positive comment about the service. One patient described her time at Riverdale as saving her life and giving her hope for the future.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- As of May 2016, average compliance for mandatory training for the child and adolescent unit was 74%. Average compliance for mandatory training on the adult unit was 77%. The service had added additional modules of mandatory training which were not included in these figures.
- Only three staff members on the child and adolescent unit and two staff on the adult unit had undertaken safeguarding training at level three. This training is a requirement of all clinical staff working in child and adolescent services through the quality network for inpatient child and adolescent services standards of the Royal College of Psychiatrists. Because the staff teams cover both units during staffing difficulties, any staff who may be required to work on both units should have received safeguarding training at level three.

However

- Both units were clean and well maintained with cleaning schedules in place that were fully completed.
- Both units had a clinic room which was clean and contained emergency equipment that was checked on a regular basis. Both units had a couch for use during physical examinations.
- The professional judgement tool was used to calculate staffing establishments. We saw this in practice when viewing one month of duty rota for each unit. Staffing levels were adjusted to ensure safety at all times taking into account bed occupancy, new admissions and periods of one to one observations.
- The provider had produced a duty of candour policy which clearly lists the roles and responsibilities within this requirement. Staff were able to demonstrate an understanding of practicing within a culture of openness and transparency.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- The Mental Health Act policy was not dated, nor did it have a date for review listed. The changes in the Mental Health Act Code of Practice which came into place in April 2015 had not been incorporated into the policy. The service managers provided us with dates, advising it had been written in April 2015 and was currently under review.

Summary of this inspection

- Average compliance with staff training on the Mental Health Act and Mental Capacity Act was 41%. None of the staff on the adult unit had received the training but staff were be expected to cover both units and should have been trained to ensure they are able to comply with the requirements. We viewed a training plan which demonstrated this training would be undertaken by all staff by the end of August 2016.

However

- We saw that physical health monitoring was in place and carried out in accordance with care plans written for the individual. Physical health checks and monitoring were overseen by two general practitioners who visited the units weekly or daily during the first 72 hours of any admission.
- We viewed care records of 15 patients, seven adults and eight young people. Care records were complete, personalised to the individual needs of the patients and covered all aspects of care. They were reviewed and updated on a regular basis.
- There was a wide range of professionals within the multidisciplinary team. These professions are recommended within guidance issued by the National Institute for Health and Care Excellence.

Are services caring?

Good

We rated caring as good because:

- We observed staff and patient interactions through the inspection on both units. We saw staff being respectful and courteous at all times. Relatives told us that the staff team are mainly supportive and respectful.
- We viewed 15 care and treatment records across both units. Care planning showed the involvement of patients, family members where appropriate and members of the multidisciplinary team. They covered all aspects of care and were reviewed on a regular basis. All patients were given copies of their care plan.
- We attended the carers group which was held monthly and always on a weekend to support better attendance by anyone who may work or need to travel. The groups provided peer support and education around eating disorders. We observed how carers shared experiences, asked questions and learned useful strategies to support family members.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- The adult service had discharged nine patients in the six months prior to the inspection, all to their home address. The child and adolescent unit had discharged 10 patients, eight to their home address and two to other providers.
- Discharge was planned and was graded through a process of day leave to home leave prior to discharge. On occasion patients had chosen to leave without completing the treatment programme. In these cases the staff made every effort to discuss options with the patients and put plans in place for support in the community.
- School staff established contact with a young person's school prior to and throughout admission. During their stay young people completed work provided by the school they would normally attend. If the school was relatively close to the unit they would assist patients to spend time in the school in preparation for discharge.
- There was a timetable of activities on both units and this varied week to week to accommodate the changing needs of the patient group for example, education, different therapy options appropriate to the individual, healthy eating groups, Pilates, yoga, family therapy, self-catering and community outings.
- There was a disabled access to the hospital. Both units could accommodate disabled patients and there was a lift to access the higher floors. Staff were aware that when young people were very underweight they had restricted level of activity and used wheelchairs to access outside areas.

However

- The access directly from the child and adolescent unit was down a small step and this was sometimes difficult to manoeuvre.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Checks to ensure directors met the fit and proper person test had not been completed.

However

- Staff and patients had an understanding of the values of the service.
- There were several forums for staff to receive feedback on the learning from incidents; de-briefs, team meetings, supervision, handover and emails.

Summary of this inspection

- Both ward managers felt supported in their roles and had the autonomy to make decisions in the absence of the service managers. The ward managers also participated in the on call rota.
- Both units were participating in the Royal College of Psychiatrists' accreditation scheme through which good practice and high quality care is recognised and services are supported to address any areas for improvement.

Detailed findings from this inspection

Mental Health Act responsibilities

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

As part of our inspection, we carried out a Mental Health Act monitoring visit on the child and adolescent unit. This was our first monitoring visit to Riverdale Clinic since the adolescent unit was registered to take detained patients. The service accepted detained patients to the child and adolescent unit only. There had been four patients receiving treatment under the Act since June 2015.

At the time of our inspection there was one young person detained under the Mental Health Act. The patient was positive about their experience as an inpatient at the clinic. They said that their rights had been explained to them by staff. They had been assisted by a solicitor and the independent mental health advocate to appeal to the Tribunal. They found the staff easy to talk to and helpful. We also spoke with a parent of the young person who spoke highly of the service and felt very involved in all aspects of her daughter's care. We could see that her rights had been explained in January and April but there was no formal system or understanding from nursing staff on how this process should be completed and updated.

The independent mental health advocate from the National Youth Advisory service visited the unit each month and held a closed group meeting with all patients.

There was a Mental Health Act administrator within the service. Although this was only part of her role she had support from the Mental Health Act manager at Sheffield Health and Social Care Foundation Trust for support and guidance as required.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider had a Deprivation of Liberty Safeguards policy and a Mental Capacity Act policy. Both were detailed and comprehensive. However, the policies were still in draft form.

Training in the Mental Capacity Act (2005) had not previously been considered mandatory, although the service had provided some training in the form of a workshop facilitated by the adult ward consultant. However, only 41% percent of the current clinical staff had attended one of these workshops. This was partly due to a high staff turnover following changes in practice and shift patterns. New staff had not yet received this training. A senior management meeting in January had identified this training as mandatory to all clinical staff and this was planned to be delivered in July 2016.

The staff had a limited knowledge of the Act and its principles. The consultant psychiatrist assessed capacity to treatment during the initial assessment and following this, in line with the Act staff assumed the patient to have capacity, unless there was reason to question this. If there was a concern regarding a patients capacity then staff would seek the support of the unit's consultant psychiatrist.

The Mental Capacity Act (2005) does not apply to young people under the age of 16 years old. Staff were aware of the requirement to use Gillick competence when assessing the capacity of young people under 16 years old.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Specialist eating disorder services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

Both units were clean and well maintained. We viewed cleaning schedules that demonstrated this was completed and managed.

Both units had completed an environment risk assessment which listed any risk with regard to ligature points and blind spots. There was clear mitigation of any potential risk for example mirrors used to support where there were not clear lines of sight.

The child and adolescent unit provided mixed sex accommodation but only had the facility to accommodate one male young person on the unit. There were no male young people on the unit at the time of our inspection. The provider was aware of this limitation and they received few referrals for male young people with eating disorders.

The clinic room on the adult service was clean with equipment that was regularly checked. The child and adolescent unit was in the process of moving into a new clinic room that was much bigger than the previous room. The room was finished and furnished but awaiting the transfer of medication. Emergency equipment was present and checked on a regular basis on both units. Both clinic rooms had an examination couch. Hand washing facilities and notices were present through the building and alcohol gels dispensers were placed in doorways, clinic rooms and dining rooms. Clinic room temperatures were monitored on a daily basis.

Medicines were safely stored and storage temperatures were monitored. Nurses were setting up a newly built clinic room for the younger people's services to afford better privacy for patients when they came for their medicines. Adrenaline and oxygen were available for medical emergencies but other drugs were not held.

There was a nurse call system available in patient bedrooms and in all communal areas of the building. There was a fob system in place that ensured only young people could access the young person's unit, and only adults could access the adult's unit.

Safe staffing

The multidisciplinary team included:

- Assistant psychologist
- Body image therapist
- CBT therapist
- Clinical pharmacist
- Clinical psychologist
- Complimentary therapist
- Consultants psychiatrists
- Creative therapist
- Dieticians
- Family therapist
- Nurses
- Nursing assistants
- Occupational therapists
- Occupational therapy assistant
- Ward managers

The nursing establishment whole time equivalents on the adult unit was:

- Qualified nurse whole time equivalents: 10
- Nursing assistant whole time equivalents: 10

- Number of vacancies – qualified nurse whole time equivalents: 1
- Number of vacancies – nursing assistant whole time equivalents: 3
- The number of shifts filled by bank staff to cover sickness, absence or vacancies from 1 Jan 2016 – 31 March 2016: 150 shifts (129 day shifts / 21 night shifts)
- The number of shifts filled by agency staff to cover sickness, absence or vacancies in 1 Jan 2016 – 31 March 2016: 88 shifts (10 day shifts / 78 night shifts).
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies from 1 Jan 2016 – 31 March 2016: 6

Day time staffing was two qualified nurses and two nursing assistants, night time staff was one qualified nurse and one support worker. The overall adult's ward staff sickness rate in the period April 2015 to March 2016 was 2%. The staff turnover in the same period was 23%.

The children's ward nursing establishment whole time equivalents (WTE) was:

- Qualified nurse whole time equivalents: 11
- Nursing assistant whole time equivalents: 12
- Number of vacancies – qualified nurse whole time equivalents: 6
- Number of vacancies – nursing assistant whole time equivalents: 3
- The number of shifts filled by bank staff to cover sickness, absence or vacancies from 1 Jan 2016 – 31 March 2016: 116 shifts (96 day shifts / 20 night shifts)
- The number of shifts filled by agency staff to cover sickness, absence or vacancies in 1 Jan 2016 – 31 March 2016: 127 shifts (62 day shifts / 65 night shifts).
- The number of shifts that have not been filled by bank or agency staff where there is sickness, absence or vacancies from 1 Jan 2016 – 31 March 2016: 19

Day time staffing was two registered nurses and three support workers, night time staffing was one qualified nurse and one support worker. The overall children's ward staff sickness rate in the period April 2015 to March 2016 was 1%. The staff turnover in the same period was 45%. The high turnover of staff was due to changes in the provision of service to undertake naso-gastric feeding. Some staff did not wish to be involved in this process and had decided to leave the service.

Where shifts had not been filled, there was always at least one registered nurse on duty on each unit. The ward managers are also registered nurses and they could step in at any time to support the units as required. There was also an expectation that the on call manager would attend the hospital should there be a requirement to ensure safe staffing levels.

The professional judgement tool was used to calculate staffing establishments. We saw this in practice when viewing one month of duty rota for each unit. Staffing levels were adjusted to ensure safety at all times taking into account bed occupancy, new admissions and periods of one to one observations.

The hospital had eight mandatory training modules prior to January this year; data protection, equality and diversity, fire safety, food hygiene, health and safety, infection control, safeguarding and safeguarding lead. Average compliance with mandatory training for staff on the adult's ward was 77%, and for staff on the child and adolescent ward was 74%. Following a review of training requirements in January 2016, several training requirements were added as essential training, RESPECT training, effective communication, prevent training, hospital life support, Mental Capacity Act, therapeutic use of observations, clinical supervision training and manual handling. We were shown a training plan by the service manager which demonstrated training was planned throughout June, July and August 2016. As the new training programme had not started prior to this inspection, the additional identified modules were not included in the current compliance figures for mandatory training.

Only 50% of nursing assistants had been trained in basic life support on the child and adolescent unit and 46% of non-clinical staff such as administrators and kitchen staff. The service had identified a new module of 'hospital life support including paediatrics' which was due to start in June 2016. The training matrix provided by the service indicated that no member of staff on the adult unit was eligible for training in basic life support, although the high vacancy rate meant that the service relied on staff from both the adult and child and adolescent unit being able to work on both units. Compliance with basic life support training on the adult unit was not clear from the training data provided.

The hospital also recorded mandatory training compliance for sessional therapists, bank staff and administrative and

support staff. Bank staff and session therapist training had a lower compliance in all modules, with an average of 49%. Compliance was lower than the average in health and safety (40%), infection control (43%), food hygiene (40%) and equality and diversity (47%).

Assessing and managing risk to patients and staff

There were no incidents of restraint or seclusion reported in the adult unit in the six months to end March 2016. The child and adolescent unit reported that restraint had been used on 15 occasions and involved three young people. All three young people were detained under the Mental Health Act and the reasons for the use of restraint were listed as assisting with naso-gastric feeding, preventing absconding and supporting to reduce the incidence of self-harm. There were no incidents of prone restraint (that is when the patient is restrained face down) or seclusion. The provider used the Respect model for control and restraint. The name for the approach was chosen by patients in NAViGO Health and Social Care Community Interest Company who developed the model. NAViGO provided initial training. Two Riverdale staff were trained as trainers.

There were two safeguarding alerts raised by the adult unit and one alert raised by the child and adolescent unit in the six months to the end of March 2016. On the adult ward 88% of staff had received safeguarding training with the service manager, ward manager, charge nurses receiving training at a higher level three. On the child and adolescent unit 88% of staff had completed online training.

Safeguarding level three training had been completed by the service manager, ward manager and charge nurse. The Royal College of Psychiatrists Quality Network for Inpatient Child and Adolescent Mental Health Services accreditation programme requires that all clinical staff working in child and adolescent mental health services have the higher level of training at level three. As units supported each other with staffing in times of need, the service managers planned to deliver level three training to all staff. This training was due to take place when dates could be arranged with the appropriate trainers.

We spoke with staff about their understanding of safeguarding on both units. All staff were able to describe different forms of abuse, how this might be recognised and how they would report it.

Risk assessments were undertaken prior to admission during the assessment process and updated on admission.

The service used an electronic system for patient recording. Staff described how the system was not suitable to meet their changing needs, stating that whilst records were available the system was complex to navigate. The provider had made arrangements for a new system to be implemented in June 2016 and this process was planned to start immediately after our inspection. This was taking place soon after our inspection. Patients on both units had a completed and up to date risk assessment which was an embedded document within the electronic records system. In addition to this, where the risk assessment indicated a risk of self-harm or suicide, an additional risk assessment was completed specifically to address these needs.

When patients joined the eating disorders programme they agreed to participate in the whole process which was structured to meet their needs and support their recovery. This meant a lack of choice in some areas, for example when to eat, a focused dining room etiquette which had some limitations (for example the number of condiments used), as well as rest times and reduced levels of activity. On the adult unit, patients were informal and could exercise their wish to leave at any time.

On the child and adolescent unit there were also some restrictions around accessing bedrooms and the use of mobile phones. This was discussed with young people and their parents prior to admission and relevant documentation completed depending on individual circumstances for example age, physical well-being and levels of competence. The patient booklet described clearly the times when mobile phones were made available for young people to use which was daily between 19:30-20:30 with additional time on Wednesdays and Fridays between 16:00-17:00. If young people needed to make contact outside of these times then staff supported this. Staff described the rationale for this as supporting young people to concentrate on their education, recovery and treatment options with limited distractions.

The hospital had a new agreement in place for the supply of medicines and for pharmacist advice, from May 2016. We met with the pharmacist, who told us they would visit the hospital once a month to review all the prescription charts and to review any medicines related incident reports. The pharmacist would be completing a clinical check and a completeness check of the prescription charts. We looked at seventeen prescription charts; these were clearly presented to show the treatment people had received.

Requires improvement

Specialist eating disorder services

The hospital consultant completed medicines reconciliation at the patient's first meeting to make sure they had a full list of their current medicines. Records showed that patients had the opportunity to discuss their medicines with the doctor but leaflets, or written information was not provided. This included leaflets about medicines prescribed off-label or prescribed outside their licenced use. Appropriate arrangements were in place for supplying patients with leave and discharge medicines.

The importance of family and friends in the recovery process was recognised as important. Visiting was encouraged but visitors were asked to avoid meal times, education periods and therapy times whenever possible.

Track record on safety

There had been two incidents reported as serious by the provider. One was a patient who had taken an overdose of medication and one was a young person going absent without leave. We viewed records from both incidents and could see that thorough investigations had been completed. Changes had been made as a result of the findings of investigations. One example of improvement, was that the conservatory door now had fob access for added security to reduce the risk of absconsion.

Reporting incidents and learning from when things go wrong

An electronic reporting system was used to record all incidents. All staff have been trained in its use. Staff knew how to report incidents and were able to tell us the process.

There were a number of formats for sharing learning from incidents, including through team meetings, handovers and by email to all staff members. There was also a monthly clinical supervision session which was provided by an external facilitator. During a recent incident, records demonstrated that on call managers had been instrumental in supporting staff both during and post the incident.

Duty of Candour

The provider had a duty of candour policy which clearly listed the roles and responsibilities within this requirement. Staff were able to demonstrate both an understanding of the duty of candour and that they practiced within a culture of openness and transparency. Patients, family members and commissioners of the service all told us that they felt the service was very open and willing to discuss any concerns or difficulties and work through them.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We viewed care record of 15 patients, seven adults and eight young people. Records were stored on an electronic system. Care records were complete, personalised to the individual needs of the patients and covered all aspects of care. They were reviewed and updated on a regular basis.

The provider received physical health information about patients prior to admission whenever possible. This was usually from the patients' general practitioner or the community mental health team that had been involved. Upon admission physical health checks were completed by the general practitioner that worked with the service. There were additional requirements that needed to be closely monitored during the re-feeding phase of treatment to ensure physical health was not compromised in any way. This included regular blood samples, temperature, pulse and blood sugar monitoring. We saw that these checks were all in place and carried out in accordance with care plans written for the individual.

On the child and adolescent unit, the process of naso-gastric feeding could be facilitated when all attempts to support young people to eat had failed and their physical condition had deteriorated to such a level that their life may be as risk if allowed to continue. This involved multidisciplinary discussion and consideration with the young person and their family as appropriate. The process also involved discussion around capacity, consent and the potential use of the Mental Health Act if necessary. We saw how one young person had a separate care plan for this. We viewed the care records of one young person who had received naso-gastic feeding on the unit which demonstrated that service had followed all aspects of the process.

Requires improvement

Specialist eating disorder services

Best practice in treatment and care

We saw evidence that therapies recommended by the National Institute for Health and Care Excellence were used every day on both units. Some of these were around family involvements, carer's forums for support, education and involving families in nutritional input around food choices and size of portions. Recommended therapy delivered by staff included cognitive behavioural therapy, body image work, occupational therapy for supporting regulated activity, shopping and cooking.

Physical health monitoring was overseen by two general practitioners, one for each unit. They attended for each admission and carried out a physical health assessment for new patients within four hours of arrival on the unit. Following an admission they attended daily for the first 72 hours to assess and alter the patients' physical observation levels based upon need. Registered nurses and support workers undertook regular routine observations as directed. Where the patient might present with an increased physical health risk, the general practitioners attended as required. The general practitioners provided an on call provision and covered each other during periods of leave. The doctors both had access to the electronic notes system and could also access this remotely. Each doctor held monthly physical health reviews as standard where each patient was seen and a review carried out. Outside of the monthly reviews they attended weekly to review any non-urgent minor physical health needs.

There was a clear process to support patients to meet their nutritional needs. Assessment began at the referral stage so that the dietician could be involved in planning an individualised eating plan on admission. This was based upon that patients' eating disorder diagnosis and their physical well- being, for example, their body mass index and blood results. Eating plans were discussed with patients by the dietician and would vary based on individual needs. Patients were weighed weekly and meal plans were adjusted to account for the rate of weight gain as appropriate. Initially all meals were prepared and portioned for the patients by the chef on duty. Portion sizes varied depending on the individual needs. There was a graded approach to increasing dietary intake monitored closely with changes in body mass index and physical health. Patients then moved through the pathway to portioning their own food, preparing snacks, eating out, eating on home leave through to self-catering options prior to discharge. The whole process was supported by the dietician with support from the occupational therapist and members of the nursing team. The 'management of really sick patients with anorexia nervosa' guidance issued by the Royal College of Psychiatrist formed the basis of the programme on each unit. There are separate guidelines for adults and young people under the age of 18. The guidance covers all areas of care including advice on physical assessment and advice on the requirements of the inpatient team.

Where the practice of naso-gastric feeding was used this was only done as last resort when all efforts to encourage the young person to eat orally had failed. Where this process was used, it required full discussion through the multidisciplinary team. Issues of consent to treatment and possible detention under the Mental Health Act were fully discussed and shared with the young person and their family. We viewed records that demonstrated this process was followed and documented. However, we did not see evidence that the service routinely included the independent mental health advocate as an independent patient representative in reviews of naso-gastric feeding. The Mental Health Act code of practice states that the Mental Health Act enables independent mental health advocates to 'help patients to exercise their rights, which can include representing them and speaking on their behalf, eg by accompanying them to review meetings or hospital managers' hearings'. We did not see that the service was actively encouraging independent representation in reviews of naso-gastric treatment under the Mental Health Act.

Several rating scales were used to support care and treatment; eating disorder examination questionnaire, the occupational circumstances assessment interview and rating scale, health of the nation outcome scales. We saw how the outcomes were used within the multidisciplinary team meetings and care programme approach reviews to monitor and evaluate treatment towards recovery and discharge planning. Both units also provided information on an ongoing basis to the commissioners of the service. Feedback from commissioners stated that the service responded well to any requested for information and complete and there were no issues with getting reports in a timely manner.

A new schoolroom with two teaching staff opened recently on the site. Patients left the building to access the school,

rather than using the previous schoolroom which was within the unit. Staff thought it was more appropriate to keep school and the unit as separate entities. School staff told us that they established contact with a patient's school prior to and throughout admission. During their stay patients completed work provided by the school they would normally attend when not in hospital. If the school was relatively close to the unit they would assist patients to spend time in their school in preparation for discharge. School staff were involved in ward handovers and care planning.

Staff regularly completed audits in areas such as infection control, care planning, risk assessments and ward environmental and ligature reviews. Information was fed back up to the hospital governance team, reviewed and action plans for improvements were discussed and implemented.

Skilled staff to deliver care

There was a wide range of professionals within the multidisciplinary team including: a consultant psychiatrist, clinical psychologist, cognitive behavioural therapist, family therapist, occupational therapist, dietician, body image therapist, creative therapist, assistant psychologist, registered nurses, support workers and access to general practitioner services.

There was a structure within the nursing roles from staff nurse, senior nurse, charge nurse, deputy ward manager through to ward manager. For support workers there were two level;, support worker and senior support worker. Requests for training and external development were discussed in appraisals and management supervision. Some staff felt they had been given lots of opportunity to develop their skills. One support worker told us they had requested extra training through her appraisal and this had been agreed allowing her to develop her skills. Another support worker told us she had requested additional training through her appraisal on two occasions but this had not been actioned. Allied professionals told us there was opportunity for additional learning but a lack of progression through their roles and sometimes they felt quite stuck in moving their development forward.

There was an induction programme which included e-learning and some face to face training to ensure it covered aspects of the care certificate. Some training was completed after induction due to availability and the small number of staff employed. New staff worked for two weeks shadowing other experience staff before being added into the shift numbers. The provider had recently appointed an experienced nurse as a workforce development manager to review and redesign the induction and training package.

Both units held regular team meetings but staff on the child and adolescent unit commented that team meetings had felt less organised and structured in the last few months since the permanent staff numbers had reduced and the use of agency staff had increased. We viewed minutes of staff meetings and found that there was a wide range of topics discussed. There was no set agenda to the meeting. The service managers also organised team days where they got together as many of the staff team as possible to undertake training, discuss service development and team building.

Appraisals were completed on an annual basis. Compliance rates for the last twelve months were:

- 70% of staff from the adult unit
- 88% of staff from the child and adolescent unit
- 100% medical staff
- 40% of other staff

Clinical supervision was delivered on a one to one basis and in a group session once a month. The standard for clinical supervision was a minimum of one session every six weeks. On both units 75% of staff had reached this standard. The service managers felt this figure was higher but there were poor recording systems in place to gather the information. Service managers told us this would be reviewed and improved.

We viewed the disciplinary procedure and saw how this had been followed in the case of dismissal of a staff member.

Multidisciplinary and inter-agency team work

A multidisciplinary team meeting was held each week on both units. Patients attended the meeting and were fully involved in the discussion and the decision making process. Discussions covered a wide range of treatment options for example involvement in community groups, home leave, family inclusion, changes to diet, body image work and a medication review. The process was patient focused and we saw good collaboration with patients able to put forward their own suggestions to address eating disorder behaviours.

Requires improvement

Specialist eating disorder services

Clinical handovers happened every time there was a change of shift and there was also a handover to allied professionals at 9am on weekdays. We attended handover on both units and found these to be effective and well structured. Staff clearly demonstrated in depth knowledge about the patient group. Up-to-date information such as risk management, care needs and planning for the day was discussed.

We found evidence of inter-agency working taking place. We saw how care co-ordinators were invited to attend care programme approach meetings and had involvement in the discharge process. The service had two general practitioners to take the lead on physical health monitoring. The commissioners of the service reported good working relations and they visited the service on a quarterly basis to hold contract reviews.

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

As part of our inspection, we carried out a Mental Health Act monitoring visit on the child and adolescent unit. This was our first monitoring visit to Riverdale Clinic since the adolescent unit was registered to take detained patients. Only the child and adolescent service is registered with the care quality commission to take admission of patients detained under the Mental Health Act. There had been four patients receiving treatment under the Act since June 2015.

The Mental Health Act policy had been written in April 2015. The changes in the code of practice had not been incorporated into the policy. The policy did not have a date showing on the document or a date for review. The service managers were able to provide us with the dates upon request, the date for review was June 2016 and the policy was currently going through the review process.

Only 41% of the current staff on the child and adolescent unit had received training in the Mental Health Act. The training was delivered by the consultant psychiatrist who also acted as the chair of the local mental health tribunal panel and was able to demonstrate that he was fully up to date with all the changes to the Mental Health Act Code of Practice in 2015.

Respect training was delivered to support the use of de-escalation and the prevention or where necessary the use of restraint. Due to the number of staff leaving the service, only 50% of the current staff team on the child and adolescent unit had received this training. We were shown a training plan by the service manager which demonstrated training was planned for staff on both units throughout June, July and August. The provider had a thorough referral process and would consider their current ability to manage and support young with high levels of need. They had a good relationship with the commissioners who understand the limitations of their provision at this time.

At the time of our inspection there was one young person detained under the Mental Health Act. The patient was positive about their experience as an inpatient at the clinic. They said that their rights had been explained to them by staff. They had been assisted by a solicitor and the independent mental health advocate to appeal to the first tier tribunal service. They found the staff easy to talk to and helpful. We also spoke with a parent of the young person who spoke highly of the service and felt very involved in all aspects of her daughters care. We could see that her rights had been read in January and April but there was no formal system or understanding from nursing staff on how this process should be completed and updated.

Leave was planned with patients and their families. Staff told us that detained patients and their carers' were given copies of section 17 leave forms. The leave form did not have a space for patients and carers to sign or a tick list for staff to record who received copies. We found that some out of date section 17 leave forms had not been marked as out of date.

There was a Mental Health Act administrator within the service, this is only part of her role and she seeks support from the Mental Health Act manager at Sheffield Health and Social Care Trust for support and guidance as required.

The independent mental health advocate from the National Youth Advisory service visited the unit each month and held a closed group meeting with all patients. The independent mental health advocate would then discuss any issues with staff with the agreement of the patient group. The independent mental health advocate visited at other times when staff or a detained young person made a referral. Contact information was on display and we received written confirmation from the advocate that the monthly meetings took place.

The ward manager and their deputy had a checklist in place for the receipt and scrutiny of detention documents. Patient capacity was assessed by the responsible clinician on admission and reviewed for specific decisions. We found

the detention documents for the one detained patient was correct. However the approved mental health professional's report was missing. The provider confirmed that they had asked the approved mental health professional for the report but had not received it. Staff told us they had not received approved mental health professional reports for the previous three detained patients.

All young people had family involvement in their care and treatment. Periods of leave and discharge were discussed thoroughly and agreed in advance.

Good practice in applying the Mental Capacity Act

The provider had a Deprivation of Liberty Safeguards policy and a Mental Capacity Act policy. Both were detailed and comprehensive. However, the policies were still in draft form.

Training in the Mental Capacity Act had not previously been considered mandatory, although the service had provided some training in the form of a workshop facilitated by the adult ward consultant. However, only 41% percent of the current clinical staff had attended one of these workshops. New staff had not yet received this training. A senior management meeting in January had identified this training as mandatory to all clinical staff and this was planned to be delivered in July 2016.

The staff had a limited knowledge of the Act and its principles. The consultant psychiatrist assessed capacity to treatment during the initial assessment and following this, in line with the Act staff assumed the patient to have capacity, unless there was reason to question this. If there was a concern regards a patients capacity staff would seek the support of the unit consultant psychiatrist.

We were informed that where a young person was under 16 they would be assessed in line with the Gillick competence and parental consent sought where appropriate. We saw evidence of capacity and Gillick competence discussions in the letters issued to young people following their initial assessment by the consultant psychiatrist. All the patients' records contained a consent to treatment form, signed by staff, the patient and their parent for patients who were under 16. However there were no records of formal capacity assessments.

The provider had not made any applications under the Deprivation of Liberty Safeguards over the last six months.

We were told that patients on the adult ward were informal and if they chose to leave treatment early staff would explain the risks and potential consequences involved however they would be able to make an 'unwise choice' and leave treatment against medical advice. We saw evidence of a patient requesting to leave a week early which had been discussed in the weekly MDT and an early discharge had been facilitated.

On the child an adolescent ward we were told young people under 16 were assessed under Gillick competence and admitted under parental responsibility. If they requested to leave treatment early staff would assess the situation and lease with their parents where this was felt to be an unwise decision. Young people over 16, who staff believed to be making unwise decisions, would be discussed by the multidisciplinary team for possible assessment under the Mental Health Act.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

We observed staff and patient interactions through the inspection on both units. We saw staff being respectful and courteous at all times. Relatives told us that the staff team were supportive and respectful. When one relative had cause to make a complaint about a staff member this was dealt with appropriately.

We spoke with all nine patients on the adult unit through focus groups and individually. Patient feedback on the staff team was largely positive and we were told that staff treated patients like a person, and had an approach which was very personalised and responsive to individual needs. We received five comment cards which told us that; the staff team were very supportive including the management; that there was a calm and friendly environment; staff always listened and there was a wide variety of forums to discuss any concerns.

We held a focus group on the child and adolescent unit after education and three young people chose to attend. Feedback was positive, we were told how the atmosphere was nice, that the unit felt homely, and staff and patients got on well together. One young person felt that staff

helped her by searching her bags for anything she might use to harm herself, she felt this helped to keep her safe from self-harm. We received a comment card from the child and adolescent unit saying staff had favourites and sometimes others could feel unsupported.

The involvement of people in the care they receive

We saw that all patients received a patient Information pack which contained useful information for example, details of the multidisciplinary team, activities, dining room protocol, rest periods, physical health, smoking arrangements, contact with families and friends and information on how to make a complaint. There was also a pack for carers which listed various information about the service, for example organisational structure, staff teams, treatment provision, and visiting times. Patients and carers we spoke with all confirmed they received the information pack and felt that it was useful and informative.

We viewed 15 care and treatment records across both units. Care planning showed the involvement of patients, family members where appropriate and members of the multidisciplinary team. They covered all aspects of care and were reviewed on a regular basis. All patients were given copies of their care plan.

There were posters on the units displaying details of the local advocacy service. We received written feedback from the advocate confirming that she attended the hospital monthly to hold meetings with patients and would attend more frequently if required. She stated that the staff were supportive in listening and responding to feedback.

We attended the carers group which was held monthly on a Sunday to support attendance by anyone who may work or need to travel. The group offered support by staff and carers told us how peer support was an important part of the group. Another part of the group included skills based learning for caring for a loved one with an eating disorder as detailed within the New Maudsley Method. The New Maudsley Method is an evidence based intensive approach where carers gain an understanding of the psychological and biological impact of eating disorders to give them the skills to help a young person's recovery. This formed part of a five week course where carers shared experiences, asked questions and learned useful strategies to support family members.

Carers and patients are also invited to give feedback on the service. We viewed the last service user satisfaction survey conducted on the child and adolescent service in March 2016. This covered a range of topics for example, types of intervention, the involvement of relatives, professional skill mix, effect of service and access. Young people listed things they liked for example, safe environment, friendly staff with good knowledge of eating disorders, amount of support provided and feeling better health wise. Some things they listed as dislikes included, having to sit in the lounge, being pushed too fast, having to go on some trips. Carers also listed things they liked about the service for example, a lovely setting with a homely feel, measures in place to ensure children do not isolate themselves, caring and dedicated staff, and safe environment. Some of their dislikes included, restrictions on visiting times although it was accepted there were good reasons for this and lack of communication regarding snack options.

We heard from patients how they could get involved in staff recruitment through attending the interview process.

Are specialist eating disorder services responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

The adult service had discharged nine patients in the six months prior to the inspection, all to their home address. The child and adolescent unit had discharged 10 patients, eight to their home address and two to other providers. There were no reported delayed discharges.

Discharge was planned and graded through a process of day leave then home leave prior to discharge. If patients decided to leave without completing the treatment programme then staff made every effort to discuss options with the patients and put plans in place for support in the community. Following discharge, there was a considerable difference in the level of specialist community support available based on the local service provision where the patient was discharged. This was discussed through care programme approach meetings and where community support was not available, the hospital could provide out-patient support if necessary funding arrangements were agreed. The service was not providing any outpatient support at the time of our visit.

Requires improvement

Specialist eating disorder services

The facilities promote recovery, comfort, dignity and confidentiality

A new schoolroom with two teaching staff opened recently on the site. Young people left the child and adolescent unit to access the school which was attached to the adult unit. Staff thought this was more appropriate, as it kept the school and the unit as separate entities. School staff established contact with a patient's school prior to and throughout admission. During their stay patients completed work provided by the school they normally attended. If the school was relatively close to the unit they would assist patients to spend time in their school in preparation for discharge. School staff were involved in ward handovers, contributed to care planning and participated in training. Both teachers had received training in Respect. They showed a good understanding of safeguarding, duty of candour and whistle blowing procedures. The school was too small to be registered for Ofsted inspections but the provider commissioned an annual review from an external consultancy. This was last completed in January 2016 and was scheduled for review the week after our visit. This review was arranged at the request of the school to evaluate the quality of the existing provision against the Ofsted criteria outlined in the school inspection handbook. The report was shared and discussed with the commissioners of the service through quarterly review meetings.

Patients on both units had full access to a range of treatment and activity rooms available both on and off the wards, but within the building and in the garden.

All bedrooms in the child and adolescent unit were single and had an en suite shower and toilet. Five of the nine bedrooms on the adult unit had en suite facilities. There were three bathrooms close by the four bedrooms on the adult unit without en suite facilities. We saw that patients had personalised their bedrooms with pictures and posters. Adult patients had keys to access their bedrooms which had an automatic locking system when the door shut. On the child and adolescent unit bedrooms were locked during the day and young people did not have keys to access. We were told this was to support attendance at meals and education with limited distraction and to reduce the level of unhelpful behaviours associated with eating disorders for example excessive exercising, binging and vomiting. Bedrooms could be accessed by asking staff who considered the associated risks involved and discussing this with the individual.

There was no payphone on either unit but all adult patients had access to mobile phones and young people on the child and adolescent unit young people had limited access to mobile phones. They could request access to a unit phone at any time to make a call outside of these allocated times or if they did not have a mobile phone or sufficient credit available on their own phone.

There was a large garden area at the back of the hospital which was split in two. The larger garden area was at the back of the adult unit with a smaller area outside the child and adolescent unit. The larger garden could be used by the child and adolescent unit by prior arrangement.

The food was cooked on site by a team of two chefs, one working weekdays and the other at the weekend. They provide cross cover for each other during holiday time. There was a fortnightly rotation, 14 days of different dishes, changed every 4-6 months. Menus were planned with the dietician and patients in line with the eating disorders programme. Patients reported that the food was of good quality. The hospital was awarded a Food Hygiene Rating of 4 (Good) bySheffield City Councilon 16 March 2015. The hospital has not yet had an inspection in 2016.

There was access to hot and cold drinks and snacks, however this was in line with the eating disorders programme which fit around meal and snack time.

There was a timetable of activities on both units and this varied week to week to accommodate the changing needs of the patient group for example, education, different therapy options appropriate to the individual, healthy eating groups, Pilates, yoga, family therapy, self-catering and community outings. The occupational therapist described how the activities are reviewed taking into account the skill mix of the staff team and the requests of the patient group.

We asked the service manager how temperature is monitored and were informed that patients with eating disorders can feel the cold much more when they are a low weight. The service responded to patients requests to adjust the temperature by providing fans or blankets as appropriate and adjusting the heating accordingly. There was no provision for cooling the temperature with an air

conditioning unit but we were told this was under consideration. Patients told us the temperature on the adult unit was over 30 degrees centigrade the previous evening. We checked the temperature the next day and this was recorded as 30.5 degrees centigrade. Patients on the adult unit told us in the focus group that the temperature on the first floor could be extremely hot and uncomfortable.

Meeting the needs of all people who use the service

There was level entry to the front of the hospital. Both units could accommodate patients with disabilities and there was a lift to access the higher floors. Some staff members mentioned that when young people are very underweight they have restricted level of activity and use wheelchairs to access outside areas. The access from the child and adolescent unit is down a small step and this could sometimes be difficult to manoeuvre.

Information leaflets were available on the units informing patients how to make a complaint, as well as information with regard to some physical health issues, different helplines and how to access advocacy and information about the local area. There was a wide range of booklets and leaflets on topics such as; self-harm, reducing stress, dealing with depression, managing anxiety, sleep hygiene, mindfulness, bulimia, anorexia, increasing self-esteem and self-worth, and tackling perfectionism.

Staff told us that interpreters could be made available to help assess patients' needs and explain their rights, as well as their care and treatment, if required.

Listening to and learning from concerns and complaints

There were two recorded complaints in the 12 months prior to the inspection. We viewed records from both complaints. One was referred to the ombudsman but was later closed. We saw that there was a thorough process for investigating complaints.

Both units had weekly community meetings which allowed patients an opportunity to discuss any concerns. Carers told us they would be happy to approach staff members should they have any need to make a complaint. Information on the complaints process is contained within the patient and carers information pack and available on both units.

All complaints were reported to NHS England via the NHS contract requirements quarterly reports.

Are specialist eating disorder services well-led?

Requires improvement

Vision and values.

The two services describe a similar mission.

- To put patients' needs first.
- To provide the highest possible standard of care.
- To treat patients' with respect and dignity.
- To promote a positive approach to recovery.
- To promote and support patients' in making informed choices.
- To place importance on valuing each patient as an individual and to ensure maximum opportunities for personal growth and development. To provide an environment where all staff were valued and every person is treated equally and with respect.

The adult service described the aim of the service as helping people return to an independent life as soon as possible. The child and adolescent service described an ethos where young people could be supported with their hopes and fears.

Staff had an understanding of the mission of the service. They were very positive about the service and proud to work there.

There were two service managers. They were very active in the day-to-day running of the service and all staff knew who they were.

Good governance

The operation of the service was overseen by a board of four directors. They were responsible for governance, approving budgets and assessing the organisations performance. The board met every quarter for a formal board meeting. The senior management team was made up of the two service managers and one of the directors. The service managers had responsibility for each of the services and one of the directors had responsibility for the non-clinical staff and operations. The senior management team met every two weeks. We reviewed minutes from

both meetings which showed a wide range of discussion for example health and safety, maintenance, review of incidents, occupancy levels, policy review, staffing levels, recruitment, training ,budgets and future inspections. The structure showed how previous actions were reviewed at the start of each meeting and there was crossover between the two meetings where items needed to be reported to the board, for example finance agreements for property improvements to improve the heating system and replace windows.

The senior management team had reviewed the essential training modules at their meeting in January 2016 and extended themes covered to include: respect training, effective communication, prevent training, hospital life support, Mental Capacity Act, therapeutic use of enhanced observation, clinical supervision training and manual handling. Only the service manager, ward managers, deputy ward manager and charge nurse had received safeguarding level three training. The Royal College of Psychiatrist guidance, quality network for inpatient child and adolescent service, requires that all clinical staff working with children should receive level three safeguarding training to ensure they can identify concerns and report them appropriately. The provider had added this into the list of essential training for all staff on both units. We were shown a training plan that demonstrated this was planned to be completed by the end of August 2016.

The provider was implementing a new process for the completion of annual appraisals. In the adult service 70% staff had received an appraisal in the last 12 months, in child an adolescent services 88% and other staff 40%.

Ulysses incident reporting system was used to log all incidents. Staff described how incidents were reported onto the system.

There were several forums for staff to receive feedback on the learning from incidents; de-briefs, team meetings, supervision, handover and emails.

Staff could identify different types and levels of abuse and knew how to report safeguarding concerns. There was a good understanding that the two services had a different referral point, the adult services through the appropriate adult safeguarding authority and children through the children's safeguarding authority.

Key performance indicators were used to monitor areas of performance in both services. Both services were commissioned through NHS England specialist services and there were monthly and quarterly performance measures around safety, complaints and incidents. Each service manager completed a monthly evaluation of staffing levels at the end of each month to monitor any shortfalls or trends that might appear.

Both ward managers felt supported in their roles and had the autonomy to make decisions in the absence of the service managers. The ward managers also participated in the on call rota.

The service managers started a risk register at the end of 2015. This showed a variety of risks with an attached action plan. Some of the areas on the register included the scheduled maintenance plan and filling nursing vacancies.

Fit and proper persons test

The provider is required to complete checks on its director to ensure they meet the requirements of the fit and proper person check. There were four directors on the board at Riverdale Grange and we checked the personnel files of four to directors to verify that checks had been undertaken.

The checks had not been fully completed on any of the directors. Missing information varied but included the following:

- No photo ID for one director
- No evidence of capacity to lead one director
- No self-declaration plus occupational health clearance where relevant all four directors
- No search of insolvency and bankruptcy register for all four directors.
- No Right to work checked for two directors

Whilst we were not aware of any issues in relation to the conduct or competency of the individuals, it is the responsibility of the provider to have systems in place to ensure these check are carried out. We asked the provider to complete these checks as a priority.

Leadership, morale and staff engagement

Staff reported good working relationships within teams.

There had been changes made in the working pattern in both units. This meant changes to the rota system with staff rotating from day shifts to night shifts over a six-week rotation, rather than working in set teams on

days or nights. The service manager told us this was to support different ways of working with patients and to improve training, supervision and staff development. The changes had not suited some staff members and they had left the service. The manager told us that this had contributed to the 45% turnover of staff on the child and adolescent unit in the last 12 months.

Staff reported good relationships with managers and felt able to raise concerns without fear of victimisation. Staff described the whistleblowing process and had an awareness of the policy.

Staff spoke in a positive manner about the service. They described being proud to be working there. They described that there was job satisfaction from seeing patients through the recovery journey from being very unwell both physically and mentally on admission to discharge at a healthy weight with a future plan. All the staff focus groups reported good team working.

We received mixed feedback on opportunities to develop. Staff on the child and adolescent unit felt the number of vacancies had impacted on opportunities to develop their skills in different directions due to changes in service delivery. On the adult unit staff told us they had made requests to take up development opportunities, sometimes making a personal contribution and this had been accommodated.

There was a culture of discussion which was open and transparent. We attended a community meeting on the adult service and patients were able to comment, make suggestions and express any concerns. We viewed minutes of the community meetings on the child and adolescent unit which also demonstrated that young people were able to discuss any difficulties or concerns. Staff described being able to have conversations with patients when things went wrong for example when a drug error was made.

Commitment to quality improvement and innovation

The adult service participated in the quality network for eating disorders accreditation for inpatient mental health services through the Royal College of Psychiatrists. This accreditation process helps to assure staff, service users and carers, commissioners and regulators of the quality of the service being provided. They were inspected in April 2016 and were awaiting feedback on their performance.

The child and adolescent service participated in the quality network for inpatient child and adolescent services through the Royal College of Psychiatrists. The network aims to demonstrate and improve the quality of inpatient child and adolescent psychiatry through a system of review against the standards. They were inspected in January 2016 and await feedback on their performance.

The child and adolescent service school was too small to be registered for Ofsted inspections but the provider commissioned an annual review from an external Consultancy. This was last completed in January 2015 and was scheduled for review the week after our visit. This review was arranged at the request of the school to evaluate the quality of the existing provision against the Ofsted criteria outlined in the school inspection handbook. The report was shared and discussed with the commissioners of the service through quarterly review meetings.

Both services are commissioned through NHS England specialist commissioning. They held quarterly contract meetings and require regular monitoring data to ensure standards of safety and quality.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that mandatory training compliance is improved.
- The provider must review the service-wide requirement, provision and compliance with life support training.
- The provider must ensure that clinical supervision is delivered in accordance with policy and records kept to demonstrate compliance.
- The provider must ensure that independent mental health advocates are included in reviews of naso-gastric treatment.
- The provider must ensure that the Mental Health Act policy is updated to reflect the changes in the code of practice 2015.
- The provider must ensure that all relevant directors are compliant with fit and proper persons requirements.

Action the provider SHOULD take to improve

- The provider should ensure that environmental temperatures are comfortable for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Mandatory training and supervision was not completed and updated in accordance with agreed standards to ensure staff maintained the necessary skills to meet the needs of the people they care for and support. Not all staff had received appropriate levels of life support training. This was a breach of Regulation 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance All checks with regard Regulation 5 which the requirement that directors be fit and proper persons had not been completed. The provider did not operate systems and processes to make sure they assess and monitor their service against Regulations 5. This was a breach of Regulation 17(1) All staff had not received training in the revised Mental Health Act Code of Practice. The provider had not completed adjusting policies and procedures to reflect changes to the code of practice and policies were still under review. This was a breach of Regulation 17(2)(a) The service was not clearly documenting the involvement of independent mental health advocates in reviews of naso-gastric treatment. This was a breach of Regulation 17(2)(b)