Ellern Mede Ridgeway

Quality Report

Holcombe Hill
The Ridgeway
London
NW7 4HX
Tel:020 8959 7774
Website:www.ellernmede.org

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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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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 Ellern Mede Ridgeway as good because:

- The service was safe, clean, well equipped and fit for purpose. Ligature risks had been assessed and fire safety arrangements were in place.
- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing behaviour which challenged. As a result, they used physical restraint only after attempts at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff provided care and treatment interventions suitable for the patient group. Staff ensured that patients had good access to physical healthcare.
- 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.
- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients were involved in developing their care plans. Patients attended ward rounds and were supported to arrive at decisions. Most patients' views were incorporated, even when they differed from the clinical teams. All patients had access to a copy of their care plan and care programme approach documents.
- There was a strong, visible person-centred culture. Staff across the multi-disciplinary team were highly motivated and inspired to offer care that was conducive to their recovery.
- Staff empowered patients to have a voice and realise their potential. Patients were involved in decisions about the service. When rooms were redecorated, patients decided on the colour. Patients also decided parts of the activity programme and the menu. The quality of food served, and range of activities available at weekends had improved since the previous inspection in March 2017.
- Staff encouraged patients to be independent and responsible for planning their meals as they progressed towards discharge.
- Staff actively encouraged families and carers to be involved. The therapy team took the lead on this and was in regular contact with families and carers, providing them with training and support. Patients were supported to maintain positive relationships with them during their time at the service.
- Discharge planning arrangements were well defined within patient care plans and started soon after a patient's admission. Patients had clearly defined recovery goals.
- The service treated concerns and complaints seriously, investigated them and invited patients and/or their carers to discuss their concerns with management.
- Governance systems were in place which supported the delivery of high-quality care. Regular meetings took place within the service to discuss overall performance and learning from recent safeguarding and other incidents. A range of regular audits were undertaken, and improvements were made as a result.
- The team had access to the information they needed to provide safe and effective care and used that information to good effect.

However,

- Staff had not followed the organisation's policy for ensuring relevant physical health checks were performed following rapid tranquilisation. Compliance audits had not been undertaken for rapid tranquilisation.
- Staff had not consistently followed best practice when dispensing medicines or reporting medicines incidents. Medications for some patients were out of stock on several occasions and the correct legal documentation had not consistently been completed. Staff had not reported these as incidents.

Summary of findings

- Reflective practice sessions were not well attended. Staff told us they had not attended any sessions. Management informed us sessions were run but staff did not attend and they were looking into this.
- Patients reported that a small number of staff could be rude and that they often used their mobile phone whilst providing enhanced observations.
- Whilst staff had a good understanding about how to support the needs of patients with protected characteristics, for example sexual orientation, there was little information available to these patients to make them feel included and welcomed into the service.
- The service did not have plans in place to ensure it complied with best practice guidance by eliminating shared sleeping arrangements by 2021.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorders services	Good 	Start here...

Summary of findings

Contents

Good

Ellern Mede Ridgeway

Services we looked at
Specialist eating disorders services.

Summary of this inspection

Background to Ellern Mede Ridgeway

Ellern Mede Ridgeway is a hospital run by Oak Tree Forest Limited. It provides eating disorder inpatient services for children and adolescents. The hospital was established in 2011 and provides treatment for up to 26 patients, both male and female. The hospital is divided into two wards and a cottage, each of which provides a different treatment programme. Lask Ward has 10 beds and offers high dependency intensive treatment for patients with highly complex eating disorders, and it can support patients with naso-gastric feeding. Nunn Ward has 12 beds and provides a recovery focused programme for patients who are stabilised and require ongoing support. Each of the two cottages had space for three patients who have been assessed as low risk of harm to self or others and are physically stable. The service has 21 beds approved for NHS England (NHSE) patients and five beds for non-NHSE patients. At the time of inspection, there were 25 patients aged between 12 and 18.

The hospital has an on-site school to provide patients with an education during their admission. Ofsted rated the school as outstanding in all areas in 2018.

The service has a registered manager in post and is registered by the CQC to provide assessment or medical treatment for persons detained under the Mental Health Act 1983, treatment of disease, disorder or injury.

At the previous inspection in March 2017 we told the provider that it should make improvements in seven area:

- The provider should ensure quality of food remains the same over the weekend.
- The provider should ensure they provide a range of activities to meet patients' need at the weekend.
- The provider should ensure they consider how patients can access private space on the wards, as bedrooms, bathrooms and communal areas are all shared.
- The provider should ensure all staff are polite, respectful and approachable when engaging with patients.
- The provider should ensure patients have copies of their care plans or are offered them.
- The provider should ensure there is enough seating for all patients in the lounge on Nunn Ward and that patients have access to private space.
- The provider should ensure patients can access information about treatment and age appropriate health promotion information.

Our inspection team

The team that inspected the service comprised of two CQC inspectors, one CQC pharmacist inspector and one specialist advisor who was a nurse consultant with a background in eating disorder services as well as child and adolescent mental health services.

Why we carried out this inspection

We inspected this service as part of our inspection programme to make sure health and care services in England meet fundamental standards of quality and safety.

Summary of this inspection

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited the clinic, looked at the quality of the environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with two parents of a patient who was using the service
- spoke with the registered manager
- spoke with 14 other staff members across the multi-disciplinary team
- spoke with the patient advocate by telephone
- looked at seven care and treatment records of clients
- attended one morning meeting, one Care Programme Approach meeting and one Multi-disciplinary team meeting
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service

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?

What people who use the service say

We spoke with seven patients and two parents. They described most of the staff as kind, caring and helpful. However, two of the patients reported that some of the healthcare assistants could be rude and unhelpful and that they spent a lot of time on their mobile phones whilst they were providing one-to-one observations on patients. Patients told us that there was a good range of activities and that most of the multi-disciplinary staff were supportive of them and helped them when needed it. Patients told us that they found the therapy helpful and that they felt listened to. Patients had the opportunity to ask questions at each multi-disciplinary meeting, but they told us that they did not always receive feedback about any outcomes following the meeting, for example, whether they had been given leave or not. Patients reported that they could sometimes wait for over one day to see a doctor for non-urgent matters. The service advised patients to raise non-urgent matters at their scheduled meeting times. Bathrooms and toilets were kept locked by the service for safety reasons, and patients told us that they sometimes had to wait a long time to use the toilet because staff were busy. Overall, patients found the staff and the service helpful and conducive to improving their mental and physical health but said that there were some areas which could be better.

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:

- Staff had not followed the organisation's policy for ensuring relevant physical health checks were performed following rapid tranquilisation.
- Staff had not consistently followed best practice when dispensing medicines or reporting medicines incidents. Medications for some patients were out of stock on several occasions and the correct legal documentation had not consistently been completed. Staff had not reported these as incidents.

However,

- The service was safe, clean, well equipped, well furnished, well maintained and fit for purpose. Ligature risks had been assessed and fire safety arrangements were in place. Staff ensured that the service was compliant with requirements for mixed sex accommodation.
- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing behaviour which challenged. As a result, they used physical restraint only after attempts at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- Staff had access to clinical information and it was easy for them to maintain high quality clinical records.
- Staff regularly reviewed the effects of medications on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as **good** because:

Summary of this inspection

- 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 were personalised and reflected the immediate assessed needs.
- Staff provided some care and treatment interventions suitable for the patient group, there was a good programme of activities in place. Staff ensured that patients had good access to physical healthcare.
- Staff used recognised rating scales to assess and record severity and outcomes.
- The staff team had a range of skills needed to provide high quality care. This included medical, psychology and therapy input. The manager and clinical lead supported staff with appraisals. The manager provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients were cared for appropriately. The team had effective working relationships with staff from services that provided aftercare and engaged with them when patients were preparing for discharge.
- Staff supported patients to make decisions about their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.
- The manager supported patients to share their views about the service.

However,

- Reflective practice sessions were not well attended. Staff told us they had not attended any sessions. Management informed us sessions were run but staff did not attend and they were looking into this.

Are services caring?

Good

We rated caring as **good** because:

- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Most staff communicated with patients sensitively, and in a kind and respectful manner. Staff spoke about patients as individuals. Patients and carers described particular staff in very positive terms.

Summary of this inspection

- Staff supported patients to be empowered, for example by encouraging and supporting them to set goals and take on responsibilities which promoted their recovery.
- Patients were involved in developing their care plans. Patients attended ward rounds and could feed into this when they were too unwell or did not wish to attend. Patients' views were incorporated into most care plans, even when they differed from those of the clinical team. All patients had access to a copy of their care plan and care programme approach documents.
- Patients were involved in decisions about the service. Patients were able to attend the patient community meeting and suggest ideas and changes which were put into practice. This included areas such as the decoration of the hospital, activity programme and food.
- Staff ensured that patients had easy access to independent mental health advocates.
- Staff involved families and carers and invited them to attend patient review meetings. They recognised many relatives lived long distances from the hospital and supported patients to maintain contact using a range of means of communication such as conference calls. They provided training and support sessions for families and carers. Staff held an annual barbecue which families and carers could attend.

However

- Patients reported that a small number of staff could be rude and that they often used their mobile phones whilst providing enhanced observations. The provider was aware of this and taking steps to improve staff engagement with patients.

Are services responsive?

Good

We rated responsive as **good** because:

- Discharge planning arrangements were well defined within patient care plans and started following a patient's admission. Patients had clearly defined recovery goals.
- Staff helped patients with advocacy. Advocates attended the service and other meetings to support and represent patients.
- The service treated concerns and complaints seriously, investigated them and invited patients and/or their carers to discuss their concerns with management.
- Patients were satisfied with the quality of food or the choices available to them, and the quality of food, and choice of activities available at weekends had improved since the previous inspection in March 2017.

However

Summary of this inspection

- Whilst staff had a good understanding about how to support the needs of patients with protected characteristics, for example sexual orientation, there was little information available to these patients to make them feel included and welcomed into the service.

Are services well-led?

Good

We rated well-led as good because:

- The service had a defined model of care and staff across the multi-disciplinary team understood how to put this into practice. The primary goal for patients was to restore weight and accomplish independent and social eating.
- Governance systems were in place which supported the delivery of high-quality care. Regular meetings took place within the service to discuss overall performance and learning from recent safeguarding and other incidents. Regular audits were undertaken, and improvements were made as a result.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt able to raise concerns without fear of retribution.
- The team had access to the information they needed to provide safe and effective care and used that information to good effect.

However,

- The service had not undertaken audits to ensure compliance with rapid tranquilisation policy and medicines incidents were not reported on the main incident reporting system.
- The service did not have plans in place to ensure it complied with best practice guidance by eliminating shared sleeping arrangements by 2021.

Good

Specialist eating disorder services

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

Summary of findings

We rated Ellern Mede Ridgeway as good because:

- The service was safe, clean, well equipped and fit for purpose. Ligature risks had been assessed and fire safety arrangements were in place.
- Staff assessed and managed risks to patients and themselves. Staff followed best practice in anticipating, de-escalating and managing behaviour which challenged. As a result, they used physical restraint only after attempts at de-escalation had failed. Staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and/or exploitation and they knew how to apply it.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff provided care and treatment interventions suitable for the patient group. Staff ensured that patients had good access to physical healthcare.
- 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.
- Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Patients were involved in developing their care plans. Patients attended ward rounds and were supported to arrive at decisions. Most patients' views were incorporated, even when they differed from the clinical teams. All patients had access to a copy of their care plan and care programme approach documents.
- There was a strong, visible person-centred culture. Staff across the multi-disciplinary team were highly motivated and inspired to offer care that was conducive to their recovery.
- Staff empowered patients to have a voice and realise their potential. Patients were involved in decisions about the service. When rooms were redecorated, patients decided on the colour. Patients also decided parts of the activity programme and the menu. The quality of food served, and range of activities available at weekends had improved since the previous inspection in March 2017.
- Staff encouraged patients to be independent and responsible for planning their meals as they progressed towards discharge.
- Staff actively encouraged families and carers to be involved. The therapy team took the lead on this and was in regular contact with families and carers, providing them with training and support. Patients were supported to maintain positive relationships with them during their time at the service.
- Discharge planning arrangements were well defined within patient care plans and started soon after a patient's admission. Patients had clearly defined recovery goals.

Good

Specialist eating disorder services

- The service treated concerns and complaints seriously, investigated them and invited patients and/or their carers to discuss their concerns with management.
- Governance systems were in place which supported the delivery of high-quality care. Regular meetings took place within the service to discuss overall performance and learning from recent safeguarding and other incidents. A range of regular audits were undertaken, and improvements were made as a result.
- The team had access to the information they needed to provide safe and effective care and used that information to good effect.

However,

- Staff had not followed the organisation's policy for ensuring relevant physical health checks were performed following rapid tranquilisation. Compliance audits had not been undertaken for rapid tranquilisation.
- Staff had not consistently followed best practice when dispensing medicines or reporting medicines incidents. Medications for some patients were out of stock on several occasions and the correct legal documentation had not consistently been completed. Staff had not reported these as incidents.
- Reflective practice sessions were not well attended. Staff told us they had not attended any sessions. Management informed us sessions were run but staff did not attend and they were looking into this.
- Patients reported that a small number of staff could be rude and that they often used their mobile phone whilst providing enhanced observations.
- Whilst staff had a good understanding about how to support the needs of patients with protected characteristics, for example sexual orientation, there was little information available to these patients to make them feel included and welcomed into the service.
- The service did not have plans in place to ensure it complied with best practice guidance by eliminating shared sleeping arrangements by 2021.

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

Staff carried out regular checks of the environment. Staff recorded and reported on any areas that required attention, for example spillages or broken items of equipment.

The ward layouts did not allow staff to observe all areas, but staff used regular observation in line with patients' risk assessments to mitigate the risks. Closed-circuit Television was available in communal areas including lounges and corridors. Staff risk assessed all patients who were admitted to the unit to assess their risk in terms of self-harm or suicidal ideation. Where risks were identified, patients received a higher level of observation in accordance with the level of risk.

There were ligature risks in the main building and in the cottage, but staff were aware of these and they were managed safely. The service had completed a ligature risk assessment. Staff were aware of the ligature points and followed plans to reduce the risk of them being used. The risk was also mitigated by regular and ongoing risk assessment of patients.

The service complied with guidance on eliminating mixed-sex accommodation. Most patients referred and admitted to the service were female. The service accepted male patients and they could be accommodated on Lask Ward or in the Cottage. The service had a female-only lounge.

Staff had easy access to alarms and patients had easy access to nurse call systems. The service had wall-based call alarms throughout the service, and a staff member carried a bleep at all times to respond to any alarms without delay. Staff could also access personal alarms when they assessed they were needed.

A fire risk assessment was carried out in 2019. The risk assessment was supported by an action plan. Most actions

were recorded as completed, and a small number were in progress. The service undertook weekly fire alarm tests and fire drills took place every six months, a record was maintained of the fire evacuations.

Fire extinguishers were available and the correct signage was displayed. All staff knew where the extinguishers were.

There were no seclusion rooms at the service.

Maintenance, cleanliness and infection control

The environment was visibly clean and clutter-free. The service had dedicated domestic staff responsible for cleaning. Staff and patients told us that the level of cleanliness was good. However, we noted that in the community meeting minutes patients had repeatedly raised concerns regarding the cleanliness of bedroom carpets as well as the temperature and flow of water from the showers. Management assured us that the showers had recently been replaced and that the problem had been resolved. Management also informed us that all patients had been offered the opportunity to have laminate flooring in their bedrooms.

Maintenance repairs were carried out. The manager informed us that repairs were carried out promptly and in accordance with the urgency of the request. However, there had been some delay in resolving the problem with the showers. There was also a planned maintenance programme in place for ongoing work such as redecoration.

Staff adhered to infection control principles, including handwashing and wearing appropriate personal protective equipment, such as disposable gloves.

Clinic room and equipment

The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff kept an emergency grab bag containing lifesaving equipment in the clinic room. Staff undertook checks to ensure all items within the bag were kept in accordance with policy. Ligature cutters were stored safety on each ward and staff knew where they were.

Staff ensured medical equipment stored in the clinic rooms was maintained in line with manufacturers' instructions. Equipment was labelled with the date it was last checked and calibrated.

Staff cleaned equipment after use and weekly in line with a cleaning schedule. Staff used a yellow plastic sharps bin to dispose of needles as appropriate.

Safe staffing

Nursing staff

Managers had calculated the number and grade of registered nurses and non-registered nurses required on each shift.

The number of registered nurses and non-registered nurses on most shifts matched the core staffing level the provider had assessed to be required. Nunn Ward and Lask Ward each had two registered nurses during the day and one at night. Both wards had six unregistered nurses during the day and night with additional support for patients who were on enhanced observation. The cottage had two unregistered nurses day and night unless there were six patients in the cottage and there would be a registered nurse on duty at night.

The manager and staff reported that there were sufficient staff deployed on each shift to keep patients safe. Additional staff were brought in to care for patients who required close observations. At the time of inspection, there were six patients on close observation.

The service was staffed safely. The service filled unfilled shifts with bank staff or regular agency staff where possible. Staff described that they could be busy at times but patients were always cared for safely. The manager and staff felt supported by senior management in their approach to ensuring the service was staffed safely.

Between the period 01 August 2019 to October 2019, 25% of registered nurse posts were vacant and 12% of non-registered nurse posts were vacant. The service had seen an increase in non-registered nursing vacancies as a direct result of the increase in establishment. The manager worked hard to ensure vacancies were filled as quickly as possible.

When necessary, managers deployed agency staff to maintain safe staffing levels. When agency staff were used, they were staff who came to the wards regularly and were familiar with patients and ward routines. All agency staff received an induction and completed a checklist before they worked on the ward. There had been a high reliance

on agency staff due to the number of patients on enhanced levels of observation. During the period 01 August 2019 to 31 October 2019, there had been three shifts which could not be filled by bank or agency staff.

There was always a permanent member of staff on shift, and we observed sufficient cover with nurses present in the communal areas of the wards.

Patients' escorted leave, one-to-one sessions with named nurses, and ward activities were rarely cancelled because there were too few staff. Patients said they could have one-to-one time with their named nurses most of the time and could speak to any member of staff when needed.

The sickness rate for the service was low at one per cent..

Medical staff

There were two full-time and one part-time consultant psychiatrists. There were two speciality doctors who worked full-time at the service. There was an on-call rota, with one consultant and one speciality doctor on-call out of hours.

Mandatory training

Staff had received and were up to date with most of their mandatory training.

Overall, staff in this service had undertaken 84% of the various elements of training that the service had set as mandatory. The service had recently introduced Eating Disorder Restrictive Intervention Support Training (EDRIST) to its list of mandatory training courses. EDRIST was a bespoke evidence-based training session focussed on improving the experience of nasogastric feeding. Staff attendance was above 75% for all individual mandatory training courses.

Staff said they found mandatory training helpful and that they were up to date with training, or booked on to the next available session for particular topics.

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection, we reviewed the risk assessments of seven patients.

Staff had completed a risk assessment for every patient on admission and updated it regularly. Staff formally reviewed risk assessments at care planning meetings and ward rounds and updated them at least every three months, plus after any incident involving the patient.

Staff prepared a risk management plan for each patient. Each risk management plan set out the risks that were specific to the patient in relation to their mental and physical health and gave details of how staff should respond to these risks. Risk assessments were individualised and considered the patient's mental well-being, for example, their risk of harm to themselves or others.

Staff identified risks which may result in a setback to a patient's progress and documented how the patient would be supported to minimise any potential impact.

Staff conducted pre-admission risk assessments to determine the patients' sleeping arrangements. Most rooms were shared with two patients in each room. A risk assessment was completed to assess the patients' dependency and complexity of their needs and they were allocated a room on this basis.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Staff discussed any changes in patients' behaviour at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings. We observed a morning meeting during our inspection, during which acuity levels, staffing and any incidents at each of the provider's locations were discussed, and found it to be thorough and effective.

Each patient had a behavioural management plan. Staff used the plan to record changes in their behaviour, based on their interactions with them, and any incidents which occurred. Staff recorded changes in a patient's behaviour and adapted their care plan to ensure that their wellbeing was appropriately managed.

Staff checked patients' vital signs each week, using the Young Persons Early Warning Score (YPEWS), this was an adaptation of the Paediatric Early Warning Score (PEWS) chart (PEWS is a tool developed by the Royal College of

Physicians, which improves the detection and response to clinical deterioration in children and adolescent patients and is a key element of patient safety and improving patient outcomes).

Staff followed policies and procedures for the use of observation and for searching patients or their bedrooms. Staff completed observation records for each patient on admission to the unit and on an individual risk basis thereafter, in accordance with provider's guidance.

Staff applied blanket restrictions on patients' freedom only when justified. Bedroom doors on Nunn Ward were kept locked at certain times during the day. Patients were required to leave their smart phones at home prior to admission. Patients were allocated basic mobile phones by the service to enable them to remain in contact with their friends and family. The service had set times when they could access their mobile phones to ensure their phones did not distract them from their school work or engaging in activities. Patients had access to drinks and snacks 24 hours per day. Bathrooms and toilets were kept locked when not in use, and young people had to ask staff to open them when needed. The front door to the unit was kept locked. A number of patients were detained and were either prescribed escorted or unescorted leave. There were some informal patients on the unit, these patients knew they could leave the building when they wanted to, and they could ask a member of staff to unlock the door. The service had policies in place to support their decision making and considered these to be 'ward rules' to support patients' progression towards discharge as opposed to blanket restrictions. Adjustments were made on an individual basis as necessary, for example we saw that one patient who was bedbound was permitted their smart phone during their admission because it was clinically appropriate. The service used a Patient Involvement in Least Restrictive Management Planning' tool (PILRIMP) to discuss patient preference and choices during their stay.

All patients at the service had a personal emergency evacuation plan (PEEP) to follow in the event of a fire or other emergency. A PEEP is an escape plan for patients who may not be able to reach an ultimate place of safety without assistance within a suitable time period. Patient PEEPs were used to identify any risks which may prevent a patient from reaching the safety point unaided with details of action required to ensure they were appropriately supported.

Use of restrictive interventions

There were no reported incidents of seclusion or long-term segregation.

There were 1089 reported incidents of restraint in the six months prior to the inspection. Of the 1089 restraints, 862 related to planned Nasogastric (NG) feed interventions, 227 restraints were in response to disturbed behaviour. The service did not use prone restraints. We were informed by the manager and through review of records that the majority of restraints related to two patients. Restraint records contained all the required level of detail in accordance with National Institute for Health and Care Excellence guidelines and the provider policy.

Staff used physical restraint only after de-escalation had failed and used the correct techniques. Staff had been trained in physical interventions specific to working with young people as part of their mandatory training. This meant that staff had the required skills to de-escalate patients who became aggressive to minimise the use of restrictive interventions. Staff knew to avoid restraining people in the prone position where possible, and to use the least restrictive form of restraint, including hand holds if possible.

The service did not conduct checks on the patients' vital signs following intra-muscular administration of rapid tranquilisation in accordance with their own policy. The service reported 47 incidents of restraint that required rapid tranquilisation in the six months prior to inspection. All restraints were managed in the supine position. Incidents of rapid tranquilisation related to two patients. We reviewed records for five incidents of restraint and found that staff had not checked patients' vital signs in accordance with the provider's policy. The rapid tranquilisation policy states that staff should record the vital signs of patients every 15 minutes in the first hour, and then once per hour in the second, third and fourth hour. Only after four hours should staff cease monitoring if observations are normal. Records showed that whilst some checks had been made during the first hour, in each patient record we reviewed the frequency was not consistent with policy, records showed that staff had not documented any checks on the patients in the third or fourth hour as required in accordance with the rapid tranquilisation policy.

Safeguarding

Staff had received training in safeguarding adults and children and knew how to recognise a safeguarding concern and refer to the local safeguarding team.

94% of staff were trained in safeguarding adults and children.

The registered manager (as a nurse), consultant and two clinical leads took the lead on safeguarding for the service and provided support to staff in relation to safeguarding concerns.

Staff could give examples of safeguarding alerts they had made. This service notified the Care Quality Commission of 14 safeguarding referrals between 30 November 2018 to 30 November 2019. Staff completed records of safeguarding referrals and submitted them to the local authority safeguarding team. Staff put protection plans in place to keep patients safe.

Staff followed safe procedures for family or friends visiting patients. Arrangements were made for families, carers and friends to visit patients in the family room. Where necessary the service involved the social worker in any engagement which took place.

The service held safeguarding meetings each month. The meeting discussed all safeguarding incidents across each of the three locations run by the provider.

Staff access to essential information

Information was available to all staff when they needed it. Staff used a combination of electronic and paper files to store and record patient care and treatment records. These were stored securely on the unit. For example, staff recorded most patient care records and incidents electronically, although there was a printed copy of patient care plans. Some records were handwritten and then scanned onto the system, for example, physical observations. All Mental Health Act records were paper based.

Medicines management

Staff had not consistently followed good practice in medicines management. Staff stored, dispensed and disposed of medicines safely, although on a small number of occasions some medicines were out of stock. Staff placed orders for medication and ensured stock levels were regularly checked and rotated; however, medication for three patients had been recorded as out of stock on more than one occasion. The service confirmed this medication did not relate to first-line treatment or present a clinical risk to the patient, and the doctor monitored the patient during this time. We discussed this with the provider who agreed to meet with the pharmacy to minimise the risk of this happening again. Unused or out-of-date medication was disposed of safely in accordance with the provider's policy. Although we noted that a small number of liquid medicines did not have the date the bottle had been opened recorded on them. We brought this to the attention of staff who addressed this without delay.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with the National Institute Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Staff monitored the side effects of medicines using a measurement scale. There was a protocol in place which outlined additional observations and health monitoring for patients who were receiving antipsychotic medication above the limits set out in the British National Formulary (BNF).

Staff checked controlled drugs and fridge temperatures daily. Records showed that fridge temperatures were not always within permissible limits. This had been raised as a maintenance request and the service had ordered replacement fridges prior to our inspection and we saw evidence of this. We noted that room temperatures where medicines were stored were not being recorded. We raised this with the manager, and the manager promptly ordered thermometers and put arrangements in place to ensure room temperatures were checked and recorded daily.

A specialist pharmacy service provided weekly checks of prescribing, including checks of compliance with the Mental Health Act. This audit showed there had been a small number of errors in relation to recording of the administration of medication under the Mental Health Act. For example, doctors had prescribed medicines that were not included in the certificates, which meant the patient had not consented or a second opinion doctor had not authorised the medicines being prescribed. These errors were promptly addressed by the medical team.

We reviewed the medicine administration records for nine patients. Records were completed appropriately. Staff signed when they administered medicines or recorded why

not. Staff noted allergies and potential adverse reactions on the patients' records. The prescriber gave staff clear directions about when staff should administer 'as required' medicines.

Audits of medicines administration records were completed by nursing staff each month as well as the appointed pharmacist each quarter.

Track record on safety

The service had not reported any serious incidents during the 12 months prior to inspection.

Reporting incidents and learning from when things go wrong

Staff knew which incidents to report and how to report them. Staff reported all incidents they should report in accordance with the requirements of the provider. However, the pharmacy audit identified medication incidents that staff had not reported. Management informed us that medicines incidents were not officially recorded on the incident log unless they related to first-line treatment or present clinical risks to the patient. We discussed this with the provider who agreed that they would look into this policy decision and make amendments to ensure there was clarity around the threshold for medicines incidents.

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. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

Staff met to discuss feedback from incidents. Debriefs were held with staff and patients following an incident. Incidents were also discussed at daily staff handovers and team meetings, and an email was produced by the provider each month to share learning from incidents across the sites.

The manager reviewed incident reports and completed an investigation where required. Serious incidents were escalated to senior management and reported to the appropriate external organisations.

Staff were debriefed and received support after incidents. The manager and staff told us that staff and patients were well supported following incidents. Staff were able to give examples of learning from incidents in the past year. For example, one staff member described how procedures for taxis bringing patients to the hospital had changed following an incident when a young person had gone absent on returning from escorted leave.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed seven patient care and treatment records during our inspection. Records demonstrated good practice in terms of assessment, treatment and risk management.

The consultant psychiatrist and/or registered manager assessed potential new patients when they were referred to the service. The service had clear admission criteria and accepted patients who were aged between eight and 18 years and had a diagnosis of an eating disorder with or without co-morbidities or pervasive withdrawal syndrome/ refusal syndrome. Patients could be informal or detained under the Mental Health Act. Most admissions to the service were planned transfers from other mental health services although on occasion emergency admissions were accepted.

The clinical psychologist had been involved in drafting positive behaviour support plans to help staff plan their support of patients with behaviour that was challenging or harmful.

Staff, including a consultant and dietitian assessed patients' physical health needs in a timely manner after admission and documented the frequency of follow-up checks required. This included a full physical health check of vital signs, electro-cardiogram (ECG) and blood tests. Staff checked patients' weight and height to start a physical health treatment plan for those with low body mass index.

Staff developed care plans that met patients' individual mental and physical health needs. The care plans we reviewed were individualised, comprehensive and recovery focused.

Staff updated care plans when necessary. Staff regularly reviewed patient care plans and involved the multi-disciplinary team, patient and their family or carer in this process. Patients' views were recorded in the patient records in most of the records we reviewed, we found that two of the patient care records did not record patient views.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. There was evidence of psychological intervention and input from the dietitian and therapists. The position of occupational therapist was vacant and occupational therapy was currently provided by activity co-ordinators and therapeutic support workers. The manager informed us that the position of occupational therapist was being advertised. Patients had access to physiotherapy and psychological therapies.

Staff followed best practice guidance when inserting nasogastric tubes for feeding. For example, the provider's policy for nasogastric feeding followed the National Patient Safety Agency guidance to safely insert nasogastric tubes.

The service offered patients evidence-based family interventions that directly addressed their eating disorder. For instance, staff held a parents' group every month. The family therapist offered parents and relatives one-to-one support, counselling and family therapy. Staff provided families and carers with informal skills training based on the Maudsley Method 'skills-based learning for carers for a loved one with an eating disorder.' This is evidence-based practice used to support parents.

Staff assessed and met patients' needs for specialist nutrition and hydration. The service offered dietetic interventions from a qualified dietitian to assess patients' dietary intake and weight restoration. The dietitian completed nutrition and hydration management plans with patients to assess nutrition intake and meal plans. These included plans to support behaviour change around food. The dietitian held groups for patients around healthy living.

The service had a clear protocol on how to manage re-feeding (both orally and through a nasogastric tube) and there was evidence of a robust multidisciplinary approach to treatment. Patients with an eating disorder can be at risk of re-feeding syndrome. This is the potentially fatal metabolic disturbance caused by the re-introduction of food after a period of starvation. Staff monitored patients closely, particularly in the early stages of refeeding for signs of cardiovascular, fluid balance or biochemical disturbance. The team requested bone density tests and pelvic ultrasound scans where indicated.

The service provided psychological interventions in line with National Institute for Health and Care Excellence (NICE) guidance. The clinical psychologist and therapists offered a range of interventions including cognitive behavioural therapy, dialectic behaviour therapy, cognitive remediation therapy, family therapy, integrative therapy, psycho-education therapy, motivational interviewing, and art therapy. Staff provided training in emotional coaching skills to parents and carers of patients using the service.

The provider used the Royal College of Psychiatrists guidelines on the Junior Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines, 2014. This is guidance on a range of areas, including risk assessing, treatments and re-feeding management. One of the consultant psychiatrists at the service sat on the Junior MARSIPAN steering group at the Royal College of Psychiatrists. Consultant psychiatry staff were also involved in developing national guidance for the treatment of eating disorders. The consultant psychiatrists prescribed patient medicines in line with national guidance.

The activities team worked with patients to design a programme of therapeutic and leisure activities separate to the school timetable, both within the hospital and the local community. In response to patients' feedback they provided an activity before lunch each day, to support patients through a time of day they often find difficult.

Staff understood the interests and strengths of patients well and worked with them to develop their interests. Staff supported patients to access opportunities in the community when they could. For example, visiting places to eat meals as well as trips to places patients requested to visit. Patients had recently requested to go to a local nail bar and staff had facilitated this.

Primary nurses met with their patients individually on a regular basis to discuss their progress and review their care plans.

Staff ensured that patients had good access to physical healthcare. The service had strong links with consultants at a local general hospital as well as Great Ormond Street

Hospital. Patients were visited by a paediatrician, physiotherapist and tissue viability nurse. Patients with long-term health conditions were referred to other secondary healthcare services when required.

Physical health records showed that staff carried out daily vital signs monitoring. These included blood pressure, temperature, oxygen saturation and blood sugar monitoring. In addition, staff carried out blood testing and electrocardiograms (ECG). An ECG checks the heart rhythm and activity. Staff supported diabetic patients effectively. Staff received training in monitoring blood sugar levels. This provided patients with effective care and treatment.

Staff supported patients to attend appointments at other hospitals in relation to their physical health. Where necessary a member of staff and/ or the patient's parent or carer accompanied patients to appointments. There was good evidence on patient files of communication between the medical and nursing staff at the unit and the hospital staff responsible for meeting the patients' physical health needs.

Staff used recognised ratings scales to determine severities and outcomes for patients. Staff used health of the nation outcome scales for children and adolescents (HoNOSCA) and children's global assessment scales (CGAS). The psychologists used the eating disorders examination questionnaire (EDE-Q) to determine the range and severity of an eating disorder in a person, and a range of other measures including the children's anxiety and depression scale, and paediatric quality of life, enjoyment and satisfaction questionnaire.

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service compared local results with those from other services in order to learn. For example, the manager conducted monthly clinical audits based on the quality network for inpatient Children and Adolescent Mental Health Services standards. These included staffing, timely and purposeful admissions and restrictive practice. They also carried out recent audits into outcomes of cognitive remediation therapy, and creative, sensory integration, and distress tolerance groups. Staff followed up the action points of audits to ensure that improvements were made when needed. Staff were involved in the design of a bespoke chair for the administering naso-gastric feeding under restraint.

Skilled staff to deliver care

The service had access to the full range of specialists required to meet the needs of patients. The team included skilled staff from a range of disciplines including qualified nursing staff on every shift, consultant psychiatrists, clinical and counselling psychologists, psychotherapists, social workers, dietitians and a team of activity workers. The service also employed an external paediatrician from an NHS trust to support with patients' physical healthcare.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of patients with eating disorders. The service ensured staff were competent to carry out their specialist role supporting patients with eating disorders. For example, 89% of care staff had completed training in monitoring patients' vital signs and 86% of staff had completed training in the safe insertion of nasogastric tubes, staff were competency assessed before being allowed to insert tubes or monitor patients' vital signs. Staff attended annual conferences specific to eating disorders to receive updates in the latest evidence-based clinical practice. Medical staff had access to advice from a local paediatrician as well as links with a specialist paediatric hospital.

Managers provided new staff and agency staff with an induction to the service. The service fully inducted new starters on a two-week training programme. This included an introduction to eating disorders. All agency staff were expected to read policies and familiarise themselves with patient risk assessments and care plans. Regular agency staff also took part in training in eating disorders and meal support at the service. There was a policy all new and agency staff were required to read and abide by, detailing steps they must take if they were new to any task at the service.

Managers and leads provided staff with supervision. Staff said they received regular supervision and an annual appraisal. Allied health professionals received clinical supervision from a member of their own profession. Records showed that staff supervision had taken place regularly and there was evidence of comprehensive discussions between the supervisor and supervisee. Supervision sessions covered both managerial and clinical supervision and were linked to the values of the service. Reflective practice sessions were ad-hoc and not well

attended. We raised this with the provider who understood the need to formalise this and ensure they facilitated staff to attend meetings going forward, management assured us this was top of their agenda.

Managers and supervisors provided staff with appraisal to discuss their work performance. At 31 October 2019, 86% of nursing and HCA workers, all medical staff, 94% of the multidisciplinary team and 80% of support workers had received an appraisal. Detailed appraisal records were held on each staff file we reviewed. Managers ensured that staff had access to regular team meetings. Team meetings were held every month, there was also a governance meeting for senior staff and nurses' meetings. These meetings gave staff the opportunity to discuss incidents and safeguarding concerns as well as any general issues relevant to the unit and the chance to exchange ideas.

Managers dealt with poor staff performance promptly and effectively. Managers took appropriate action and followed the provider's disciplinary policy as required.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. The service held weekly multi-professional meetings that staff from all disciplines attended. During the inspection, we attended a patient's care programme approach meeting and a multidisciplinary meeting. We noted that there was input from each discipline, and a strong emphasis was placed on advocating psychological therapies. All staff were very positive about the multidisciplinary team and said they worked together as equals in planning patient care and treatment. They said they were able to present different points of view and felt listened to by colleagues. However, they acknowledged that there was room for improvement in communication between the multidisciplinary and nursing team.

Regular academic sessions were held for the multi-disciplinary team, including input from each discipline. Recent sessions covered stigma, narcissism, personality disorders, and distress tolerance techniques. The service had effective handovers between changes in nursing shift and we observed this taking place. The lead nurse from the out-going shift led the handover and briefed all incoming staff about each patient on the unit, and any incidents which had occurred. Staff provided handovers to other services when patients were transferred.

The service had effective working relationships with teams outside the organisation. The service was in regular contact with patients' local team care and involved them in care programme approach meetings.

Staff also communicated regularly with NHS England, who funded most patients' care, social services, patients' GPs and other organisations that provided support to the patients.

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

As of 7 January 2020, 89.5% of staff had completed mandatory training in mental health law. Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator was based at the service. Staff could access support and advice from the Mental Health Act office during their working hours and from the consultant or manager out of hours.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice. Policies were regularly reviewed to ensure they took into account the latest guidance, and any local changes

Patients had easy access to information about independent mental health advocacy. The service provided all detained patients with written information about their rights under the Mental Health Act. This information included the contact details of the advocacy service. The service also displayed contact details of advocacy services on a notice board in a communal area. The advocate visited the service each week and attended the patients' ward round. The advocate could be contacted by patients by telephone on request.

Staff understood the Mental Health Act and how this affected patients under their care. Staff explained to patients their rights under the Mental Health Act in a way that they could understand.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this

has been granted. The doctor granted patients leave as part of their therapeutic intervention. Clinicians had clearly recorded the start and end date of patients' leave and an overnight address where this was applicable.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. Staff at the Mental Health Act office stored original documents in a locked cabinet.

Staff undertook audits of the Mental Health Act to ensure relevant paperwork was present on the patients' files.

Good practice in applying the Mental Capacity Act

Training for staff in the Mental Capacity Act was mandatory and 87% of staff had completed the training. Staff said they had received training in the Mental Capacity Act (MCA) and understood how the MCA related their professional practice.

Staff had a good understanding of the Mental Capacity Act, and the five statutory principles. Staff knew how to support patients who lacked capacity to make decisions about their care. The Mental Capacity Act applies to people over the age of 16. For consent and capacity in children and adolescents, staff referred to guidance on Gillick competence. This is a test in medical law to decide whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they can give informed consent.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent. The treating clinician's assessments of patients' capacity to consent to treatment was recorded on all records we reviewed. These assessments were revisited regularly in ward review meetings.

When patients lacked capacity to make a specific decision, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

Staff understood the need to seek consent from patients before providing care. For example, if a patient required insertion of a nasogastric tube due to malnutrition and refusal to take food orally, staff sought the patient's consent. If they had concerns about the validity of the consent or the capacity of a patient to make this decision, staff requested an assessment under the Mental Health Act.

The provider had policies for the Mental Capacity Act this was available for staff electronically and in a policy folder.

Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

Are specialist eating disorder services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients was mostly positive, although patients had mixed views about the attitude of some staff. Patients told us that most of the team were exceptional, friendly, responsive and sensitive, but two of the patients told us that approximately half of the healthcare assistants could be rude and unhelpful. Some patients also reported that on occasion, some healthcare assistants spent time on their mobile phones during one-to-one observations. The provider was aware of this and taking steps to improve staff engagement with patients. The majority of staff we observed showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. They also told us that staff could be loud at night time, which disturbed their sleep.

Most staff communicated positively with patients and their carers. Staff went the extra mile to build relationships with patients and those close to them. Patients were placed by other services from across the UK, which meant that the parents of some patients lived some distance from the service. Staff kept in close contact with parents and ensured they were involved in decision making where appropriate to do so. Staff were caring, respectful and supportive and took the time to ensure families felt included in the patients' care. Most parents we spoke with told us that the service was excellent at communicating, although we were informed that it could be difficult to get through to the ward depending on which staff were on shift.

Staff said they always put patients first and maintained a positive and hopeful attitude when working with patients. Staff showed a deep interest in patients and were alert to signs of progress, however small, and celebrated these.

Good

Specialist eating disorder services

There was a strong, visible person-centred culture amongst most of the team members. Staff were highly motivated and inspired to offer care that is kind and promotes people as individuals. Staff had an excellent understanding of what it meant for a patient to have an eating disorder, and how the patient and their family might be affected by this.

Staff were exceptional at enabling people to be independent as they progressed towards discharge. For example, the dietitian spoke with the patients and their families at length to ensure everyone was informed about making healthy and nutritional food choices that were in keeping with the patients' religious beliefs as well as individual preferences.

Most staff were patient in their approach, persistent and worked with patients over long periods of time to effect change. Staff were highly committed to each patient and put in the necessary time and effort on an individualised basis to ensure positive outcomes were reached. For example, staff had worked with one patient who was electively mute for many months and made significant progress in supporting them to communicate verbally.

Staff helped patients celebrate their birthdays. One staff member told us of their pride in enabling a young person to attend their family Christmas dinner with staff support, a significant achievement for them.

Staff supported patients to understand and manage their care, treatment or condition. Staff and patients told us how some patients had progressed since being at the service through the support and care of the staff and the activities that were taking place.

Staff knew patients well. They were familiar with their histories and recognised changes in mood and behaviour. They worked patiently with people to build trust and improve engagement. Patients said most staff treated them well and behaved appropriately towards them but that some of the healthcare assistants could be rude and unhelpful.

Patients reported that staff always knocked and waited before entering their room and respected their privacy and dignity.

Staff maintained the confidentiality of information about patients. Handovers, multidisciplinary meetings and ward rounds all took place in a designated room to ensure discussions about patients could not be overheard.

The service had received 44 compliments within a 12 month period.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the service. Patients received an information booklet on admission that included information about the service, including information about activities at the service and patient rights. Further information about the service and treatment of eating disorders was available on the providers website. Staff also took the time to speak with patients who were new about the service and what they could expect.

Staff asked patients for their input about how they would like to be cared for. The service had introduced Patient Inclusion in Least Restrictive Intervention Management Planning (PILRIMP). This is a framework for exploring and recording patients' wishes in advance, identifying choices, triggers, and support in relation to restrictive interventions. This was designed for patients to provide information to staff about how they would like to be treated when they are unwell. For example, one person preferred for staff not to speak to her when she was receiving personal care or having an NG feed. Other patients described their preference for how they should be treated if they needed to be restrained. Patients reported that PILRIMP made their experience more comfortable and that it meant they felt listened to.

Staff involved patients in care planning and risk assessment. Staff supported patients to include their views in their care plan, and the patient voice came across well in five of the seven care plans we reviewed. The care plans for two patients did not clearly show their input. Ward rounds took place weekly. Patients were invited to attend every other week, and they were asked for their views on the alternate week. We attended the ward round for one patient and reviewed records, the multidisciplinary team considered patients' requests seriously. Patients told us they often did not receive feedback about decisions made in their absence, for example, whether they had been granted leave or not. All patients had access to a copy of their care plan and care programme approach (CPA) documents, which were kept locked away for confidentiality reasons.

Good

Specialist eating disorder services

Staff were very positive about patient recovery and supported each patient to make progress as an individual. Staff communicated with patients so that they understood their care and treatment. Staff held regular individual sessions with patients. Staff also involved patients in their Care Programme Approach (CPA) meetings. However, several patients said that they did not see their consultant psychiatrist as often as they would like.

Patients' artwork was on display throughout the premises. This included blackboards for patients to express themselves and a series of posters. These recorded the views of young people about how they wanted to be treated and covered a range of situations, which included "when I'm tearful," "when I'm silent," "when I'm angry," and "when providing meal support." Each patient had designed their own personalised placemats for meal times.

Staff involved patients in decisions about the service when appropriate. Patients met each week with staff in community meetings. Minutes of the meetings were taken. We noted that some issues came up repeatedly and it could take time to resolve these issues, for example, maintenance of the showers was a regular theme. Patients had also raised concerns about the cleanliness of the carpets in their bedrooms. We were informed that senior management team had recently approved for patients to have laminate flooring in their rooms if they wished to do so. Staff had also listened to patients about the need for some quiet space, and one of the rooms on Lask Ward had recently been converted so that patients could have somewhere private to go.

Patients were asked to provide feedback about the service at the community meetings. There was a suggestions box in reception. The service also undertook an annual survey. The most recent survey took place in December 2018. An action plan had been developed and most identified actions completed, with some in progress and target dates for 2020. Management informed us the next survey was due to take place in January 2020.

Staff ensured that patients could access an independent advocate. A patient advocate visited the service every week and contact details of the advocacy services were displayed on the notice board of each unit. They also provided individual support to patients at ward rounds and CPA meetings, and had started to attend community meetings. We spoke with the advocate, and they noted that the service was responsive to their feedback. They noted that recycling and reducing the use of single-use plastics was an important topic for many young people in the service. For example, they had recently requested for the service to provide plate covers to replace the use of clingfilm, and provision of reusable straws.

Patients were involved in decisions about the service. Most changes to the service were discussed with patients at community meetings. Patients decided on parts of the activity programme as well as the food menu.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff kept in contact with family members and carers with patients' consent and encouraged them to be active in supporting the patient. The social worker took the lead on work with families and carers. Most families were very involved in patient care and attended ward rounds and CPA meetings. Families lived in various locations across the UK and the service kept in regular telephone or email contact where appropriate. A parents' group was held monthly, including elements of psychoeducation and support. Topics covered included emotional regulation and emotional coaching skills, with sessions from the service's multi-disciplinary team such as a session on 'fear foods' by the dietitian. Sessions also included meeting a young person who had previously been at the service and had recovered and a parent of a young person who had recovered.

Parents spoke very positively about the support offered by the family therapists, and how they worked collaboratively, offering regular opportunities to give feedback about the process.

Staff enabled families and carers to give feedback on the service they received. Staff invited families and carers to attend meetings to review patients' individual progress and support the patient. Families could provide feedback to staff directly at these meetings. Patient records showed communications with families including invitations to attend review meetings, if the patient consented. All carers received a pack containing information about the service. There was a suggestions box available should parents wish to provide feedback.

Are specialist eating disorder services responsive to people's needs?

Good

Specialist eating disorder services

(for example, to feedback?)

Good

Access and discharge

Bed management

The service accepted referrals from community and inpatient services. Once a referral was received, senior clinicians attended a referral and allocation meeting to decide where the patient would be best placed. The service accepted national and international referrals. Twenty-one beds were funded by NHS England, and five beds could be spot purchased.

The service reported an average bed occupancy of 92% between the period 1 November 2018 to 31 October 2019.

There were often delays in patients accessing a bed on Lask Ward. As a high dependency unit this ward had a long waiting time, which could be up to nine months. This was due to the high demand and specialist nature of the service. The service had agreed in discussion with NHS England that they would cap their waiting list at five patients due to the high demand. At the time of the inspection, there were five people on the waiting list for Lask Ward and two for Nunn Ward or the cottage. Regular meetings were held with the commissioners as well as the referring service to discuss new referrals as well as discharges. Staff from the service visited patients to assess whether they could meet the needs of the patient prior to admission. Delays in accessing a bed were often due to the specialist nature of the service.

The average length of stay for the service was 350 days between the period 1 November 2018 to 31 October 2019: 269 days for Nunn ward and 640 days for Lask (this included one exceptionally long stay patient of 1640 days that skewed the figures). The service aimed for a length of stay of between six to nine months on Nunn Ward and the cottage and two years for patients on Lask Ward. We were informed by the service that they were working in partnership with NHS England to meet these targets. Most patients on Nunn Ward and the cottage were admitted from the community. Patients on Lask Ward were mostly admitted from other tier 4 services where treatment had not worked well for them.

Patients were not moved between wards during an admission unless this was based on a clinical decision. There was access to a bed on return from leave.

Discharges out to the family home, and transfers to other inpatient wards always followed a graduated approach. The patient would usually be prescribed leave to initially spend several hours at home with their family or to another placement with a series of overnight stays until the patient and staff felt confident that the patient was ready to be discharged from the service.

Discharge and transfers of care

Between 1 November 2018 and 31 October 2019 there were six discharges from Lask Ward and 21 discharges from Nunn Ward.

Discharge planning began on admission. Patients' discharge planning was documented in their care plans. This provided staff with the opportunity to ensure patients progressed on a discharge pathway which was right for them. Staff supported patients to set goals so that they could make progress towards discharge.

Patient discharge arrangements were discussed at ward rounds and the MDT meetings. Discussions focussed on how the patient could be supported with their discharge; this included the patient's personal goals relating to their health, weight and mental well-being, as well reaching agreements with their school and family.

The manager held regular meetings with commissioners to discuss the patients they provided funding for. Meetings included discussions around discharge and transfer and whether anything additional was required to facilitate the discharge.

Discharges were delayed for a range of reasons. The service aimed for a length of stay of six to nine months on Nunn Ward and 18 to 24 months on Lask Ward although there were patients on each ward who exceeded this timescale. The manager informed us that the primary reasons for delayed discharge were due to the confidence of community teams to work with these patients, as well as breakdowns in family relationships. The manager informed us that they had made efforts to work more closely with community services to help them gain confidence in caring for patients as well as involving social services at a much earlier stage in the discharge process.

Facilities that promote comfort, dignity and privacy

Sleeping arrangements varied between wards and the cottages. Space on the wards and in the cottages was limited.

There were two single bedrooms on Lask Ward and two single bedrooms on Nunn Ward. All other bedrooms were shared, two patients to each room. Screens were available to protect patients' privacy and dignity but patients told us they preferred not to use them. Most of the patients we spoke with told us they preferred to share bedrooms. Bedrooms were small but patients could personalise their rooms and we saw that some patients displayed photos and personal belongings.

Young people shared bathrooms and had reported that there had been frequent problems with obtaining hot water over the last year particularly in one shower on Nunn Ward, and at the cottage. The issue had been addressed prior to the inspection. A small number of areas were in need of refurbishment, including one sofa in the lounge on Nunn Ward, which was very worn, and some areas in need of repainting.

There was limited space at the service, but staff and patients had access to the full range of rooms and equipment to support treatment and care. These included a quiet room, activity room and dining room for each ward. Patients admitted to the cottage had access to the facilities on Nunn Ward. Recently a bedroom on Lask Ward had been converted to a quiet room but patients across the unit told us they would like more quiet space. This was particularly important for patients on Nunn Ward because they were unable to access their bedrooms for long periods of time during the course of the day. Most patients from Nunn Ward had chosen to have their meals in the activities room downstairs, with only a small number using the dining room on Nunn Ward.

There was a family room off the unit where patients could meet visitors. Patients who were well enough and either informal or had been granted leave, could meet their families and visitors outside of the premises if they preferred to do so.

Patients were able to make telephone calls in private. Patients were able to access their mobile phones. The amount of access patients had to their phone was assessed and varied between individuals. Most patients had their own personal phone, but they could access a phone in the family room where they could speak in private if necessary.

Patients had access to outside space. There was a spacious garden area between the cottages and the main unit. Patients on each ward and the cottages could access the garden and staff accompanied patients. Most of the patients we spoke with said they had enough access to fresh air.

Different food options were available for patients which met dietary and cultural needs of patients. Patients reported that the food was fresh and of good quality. There was a choice of meals which patients selected each day. On occasion the chef attended patient community meetings to gather feedback about the menu and food options available.

At the previous inspection in March 2017, we found that there were not always sufficient activities available to patients at weekends. At the current inspection, patients told us that there were more activities available at weekends, with one of the activity coordinators, working on one day each weekend. Staff said that they planned activities for the weekends during weekdays. A wide range of activities were available to patients outside of school, arts and crafts were particularly popular including origami, bracelet making, marbelling, knitting, crochet, and tie dying. Patients had access to computers, a games computer, a piano keyboard, books, games, and arts and crafts materials. Patients told us that they found the provision of an activity session just before lunch, particularly helpful, and this had been included in the timetable at their request.

There was a vehicle and driver available, and fortnightly trips out to a range of activities including the cinema, theatre, shopping, parks, the zoo, mini golf and laser tag. During the school holidays a full activities programme was provided to keep patients occupied. Patients told us that they particularly enjoyed regular visits to the service from two therapy dogs.

Patients' engagement with the wider community

Staff ensured that patients had access to education. There was a school on-site, which Ofsted rated as Outstanding in all domains in 2018. Patients who were well enough were expected to attend the school during the week. Staff took the time to liaise with patients' own schools to ensure they

maintained contact with a staged return. Patients were encouraged to plan their educational goals and the education team also contributed to the patients' care plans.

Staff supported patients to participate in activities outside of the unit. Staff directed patients to other services when appropriate and, if required, supported them to access those services. Patients were encouraged to access groups in the community, many of the patients spent time at the local stables or farm. Depending on their stage of recovery patients could attend regular boxing sessions and swimming sessions and could chose trips out. Recently the patients had opted to visit a nail bar, they also had trips to the local leisure centre and visited different cafes and restaurants to share meals with each other.

Meeting the needs of all people who use the service

The service was accessible to patients with disabilities. There was a lift available and one of the bedrooms on Lask Ward had disabled access as well as an accessible toilet and bathroom. There were three mobility hoists available for use throughout the hospital.

There was a staff photo board at the service reception, so that patients and parents/carers could see who staff were and what their names were.

There was a range of written information available on wards about external services, such as advocacy.

Information about mental health diagnoses, treatments and support was provided in welcome packs. Additional age appropriate health promotion information was not available on the unit, for example about bullying/ cyber-bullying or sexual health.

The service had a website that gave clear information about the service, including copies of information packs and anonymous feedback from previous clients.

The service accessed interpreters for patients whose first language was not English although this was rarely required. The majority of patients spoke English as their first language. Information leaflets available in reception and on the wards were written in English but could be obtained in other languages if this was necessary. There was limited information available in easy read formats, although there was easy read information available about the Mental Health Act on site and on the service website.

Staff ensured that patients had access to appropriate spiritual support. There was a multi-faith room on site and staff supported patients to attend places of worship and spiritual significance if the patient wished.

Staff were supportive of patients who were LGBT+ and described how the service demonstrated it was inclusive in its approach to patients and carers, regardless of their sexual orientation or other protected characteristics. The service had cared for a number of transgender patients and made adjustments to bedroom arrangements to ensure all patients felt comfortable. However, there was no information around the unit which indicated to patients that staff were committed to an inclusive approach. For example, there were no information leaflets to welcome patients with protected characteristics.

Listening to and learning from concerns and complaints

During the previous 12 months, the service received ten complaints. One complaint had been upheld and two partially upheld. Management referred complaints to external agencies for investigation in accordance with guidance.

Patients knew how to complain or raise concerns. Information on how to make a complaint was available on the noticeboard and there were leaflets around the unit. Patients also had the opportunity to raise complaints or concerns at the weekly community meetings.

Staff knew how to handle complaints. The service had a complaints policy and staff knew how to access this. Informal complaints were dealt with as they arose. If patients wanted to make a formal complaint staff supported them to do this.

When patients complained or raised concerns, they received feedback. When a formal complaint was made that required investigation, patients were contacted by the manager acknowledging their complaint. A written response was sent to the complainant. Most complaints were responded to in less than 30 days and in line with the organisations policy. Three complaints had exceeded this, the longest being 42 days. In each case the manager had written to complainants informing them that a response had taken longer than expected due to external investigation. Complainants were also invited to meet with the manager to discuss their concerns.

Good

Specialist eating disorder services

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We were told that complaints were discussed at handover meetings and the team meetings.

Are specialist eating disorder services well-led?

Good

Leadership

Leaders had the experience to manage the units safely. The senior management team had been in post for several years, the registered manager and managing director came to the service with previous managerial experience in a mental health setting including eating disorders.

Leaders had an understanding of the services they managed. The registered manager and managing director were aware of the strengths and weaknesses within the service. They understood what the local risks were and what quality assurance measures were in place. They knew all the patients and had a good understanding of each patient's individual day to day needs. They recognised that a coordinated approach was needed to ensure a high-quality service was provided to support patients to become well and learn to live independently.

Leadership development opportunities were available. There was a clear staffing structure and nurses and health care assistants had the opportunity to progress within the service although development opportunities were limited, due to the small size of the organisation. However, the service supported staff who wanted to progress including attending external events and studying to gain additional qualifications.

Vision and strategy

Managers and staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values and mission statement for the service were created with input from both patients and staff. The provider's vision was set out in the service's Quality Strategy: "Ellern Mede is committed to offering specialist, safe, effective eating disorder care in a holistic approach to facilitate physical, mental and emotional recovery. We aim to offer the most comprehensive specialist eating disorders treatment pathway available anywhere in the UK. We believe in treating each person as an individual and we focus on their needs." The vision was underpinned by core values, which were as follows: to engage with and treat our young people with a holistic approach to facilitate their physical, mental and emotional recovery; to provide quality services, comprehensive information and to strive for constant improvement; to inspire our staff to build a positive environment; to respect the dignity of our patients; to work in co-operation with the family of our young people by including them in the treatment programme; and to work together with honesty and respect and to listen to and act on feedback. The service aimed to achieve this through putting patients first, holistically meeting their needs and empowering patients and a commitment to progressing them through their recovery journey.

The manager was able to explain how they worked to deliver high quality care within the budget available and how they supported staff to do this. The manager was responsible for working within budget and ensuring that staff who worked for the service provided good care to patients. A poster about Ellern Mede values was on display at the service reception.

Management had not considered the requirement to become compliant with CQC guidance on shared sleeping arrangements. In State of Care in Mental Health Services – 2014/2017, CQC said that 'in the 21st century, patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers – some of whom might be agitated'. Health Building Note 03-015, which applies to all NHS-funded care, states that 'since 2000, all new-build [acute mental health] units have been required to incorporate single bedrooms, ideally with ensuite facilities' CQC's position is that, 19 years after it became an expectation that new-build or refurbished wards have single bedrooms, this should now be true for all wards. Also, this should be the case for all types of mental health and learning disability wards.

Culture

Staff felt very proud to be working in the service. They praised the service for the support they received and how the team worked well together across the service.

Staff felt respected, supported and valued. Staff had not reported any cases of staff bullying or harassment and told

us that they felt supported by their colleagues. The team worked well together and there was a positive staff culture, although staff acknowledged that communication between the nursing team and wider multi-disciplinary team could be improved.

Staff felt well supported by the manager and the rest of the multidisciplinary team. They felt able to speak up if they had any concerns and were confident they would be listened to.

Staff appraisals included conversations about career development, although internal opportunities were limited due to the size of the organisation. The service had a system whereby patients and relatives were able to refer staff for 'extra mile' nominations for exceptional care and support.

Staff reported that the provider promoted equality and diversity in its day to day work and when opportunities for career progression arose. Staff members came from diverse backgrounds.

The sickness rate for the service was low at one per cent.

Staff were aware that they could access support for their own physical and emotional health needs through the service's occupational health service. The manager informed us that they referred employees to the service in accordance with provider policy and staff could also make self-referrals.

Governance

Governance arrangements were in place that supported the delivery of the service. There was a clearly defined care pathway for patients which outlined what they could expect from each discipline as they progressed through the service. This was supported by a good programme of activities for patients.

The service had identified risks and monitored the quality and safety of the service provided. Regular meetings were held where essential information was discussed.

Staff participated in local audits. Examples of audits included care plan audits, medication audits and infection control audits. The audits supported managers to identify areas requiring improvement. However, the service had not conducted audits on rapid tranquilisation, and during our inspection we found that staff were not performing post rapid tranquilisation physical health monitoring in line with the organisations policy. We also identified that medicines incidents were not being formally reported under the providers incident management system.

Staff understood the arrangements for working as a team and linking with external organisations. For example, staff worked hard to engage with the patients' schools, local team, social workers and their funding organisation (mainly NHS England).

Staff told us they attended team meetings, these were held at ward level. There was also a Quality Safety and Strategy meeting and Senior Management team meeting. Meetings covered standard agenda items, such as incidents and safeguarding incidents. Managers were aware of the main concerns raised by staff and patients, including recruitment and retention of staff, and lack of space within the hospital building. They had taken some action to address these issues, including ongoing recruitment initiatives and converting a bedroom into a quiet room on Lask Ward.

Management of risk, issues and performance

The manager maintained a risk register. Staff had access to the risk register and could escalate concerns to the manager. The manager assessed risks for their likelihood and impact and added risks to the register if they met agreed criteria. The risks identified on the risk register matched concerns discussed with staff during the inspection. .

The provider had plans for emergencies, which included contingency arrangements for adverse events. The manager knew how to access the plan and would refer to it in the event of an emergency. The continuity plan included basic instructions for staff to follow in the event of a major incident, or disruption to the service due to loss of utilities or an unexpected event.

Information management

The service used systems to collect data that were not over-burdensome for frontline staff. Data was collected and used to produce regular reports for the senior management team which provided oversight of the service.

Staff had access to the equipment and information technology needed to do their work. The information

technology infrastructure, including the computer and telephone systems worked well. Arrangements were in place to ensure that data was backed up safely and securely.

Information governance training (data protection and EU general data protection regulation) was included in the mandatory training modules. The training informed staff how to maintain confidentiality. Staff compliance with this training was 84%.

The manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. For example, the manager could access data on the number and type of incidents which had occurred during a given period. The manager also kept a record on the number staff who had attended mandatory training and the rate of staff sickness. Performance information about patients' length of stay and discharge rate was also available.

Staff made notifications to external bodies as needed. For example, one serious incident had been reported to the police and clinical commissioner. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about the possible abuse of patients.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff kept patients up-to-date by displaying information on notice boards and discussing relevant matters with them during one-to-one meetings with their named nurse. Staff received regular updates at daily handover meetings and via emails that kept them informed of developments and incidents.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs, however a survey had not been undertaken since December 2018. Management confirmed the next survey would go out during January 2020. Patient community meeting minutes confirmed that patients had the opportunity to provide weekly feedback, in most instances staff provided feedback about action taken and where patient wishes could not be fulfilled they were told why. Although we noted that issues around cleaning of carpets and maintenance of showers arose on a regular basis, information provided by staff was not always constructive or helpful to explain to patients what action was being taken.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.

Managers and staff embraced innovation and tried hard to improve the quality of the service. For example, the service had developed and implemented a tool that was used internally to support and create dialogue with patients and parents called the patient inclusion in least restrictive intervention management plan (PILRIMP). PILRIMP was a tool designed to support and create dialogue between patients and staff in advance of a patient requiring a restraint. The aim of PILRIMP was to ensure patients' wishes were reflected and acted on in the event the patient required restraint.

The service had introduced Eating Disorder Restrictive Intervention Support Training (EDRIST). EDRIST was a bespoke evidence based physical and theoretical intervention programme developed specifically for young people with eating disorders and included a significant focus on planned nasogastric (NG) feeding. Training included behaviours associated with eating disorders. Staff at the service were preparing for external validation and assessment of EDRIST in 2020.

The service had been involved with designing and developing an evidence-based NG feeding couch specifically for feeding using restrictive interventions.

The service had not participated in any accreditation scheme, such as quality network for inpatient CAMHS (QNIC). This is a quality standard programme of peer reviewers measuring the service against the standards. However, the hospital had signed up with QNIC and partake in annual QNIC peer review visits.

Outstanding practice and areas for improvement

Outstanding practice

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Areas for improvement

Action the provider MUST take to improve

The provider must ensure that staff complete the required physical health observations on patients following administration of rapid tranquilisation or record reasons why this was not done in accordance with best practice and the service guidelines. Regulation 12 (1) (2)(a)(b)

The provider must ensure that medication for patients is administered as prescribed and that adequate precautions are taken to ensure medication does not go out of stock. Regulation 12 (1) (2)(a)(b)(g)

Action the provider SHOULD take to improve

The service should ensure reflective practice sessions are flexible to encourage staff attendance.

The provider should ensure all staff are polite, respectful and approachable when engaging with patients and that they do not use their mobile phones whilst providing care to patients.

The provider should ensure there is sufficient information available to patients with protected characteristics which makes it clear staff are approachable and welcoming.

The provider should ensure that audits are undertaken on the administration and post monitoring observation of rapid tranquilisation to ensure staff are complaint with the providers policy.

The provider should ensure that its threshold of medicines related incidents is reviewed.

The provider should develop plans to ensure that it is compliant with best practice in eliminating shared sleeping arrangements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment