The Napier Clinic Limited

THE ABBI CLINIC

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated it as good because:

- The service provided safe care. Premises where patients were seen were safe and clean. Staff assessed and managed risk well and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment and in collaboration with patients. They provided a range of treatments that were informed by best practice guidance and suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The team included the full range of specialists required to meet the needs of the patients. Managers ensured that these staff received training, supervision and appraisal. Staff worked well together as a multidisciplinary team and with relevant services outside the organisation.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions.

However:

- Clinical premises were not accessible for people with mobility needs.
- Policies and procedures did not reflect the service provided.
- Patient care records and staff records were not complete and contemporaneous.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	

Summary of findings

Contents

Summary of this inspection

Background to THE ABBI CLINIC

The ABBI clinic was registered with CQC on 15 July 2020 to provide the regulated activity Treatment of Disease, Disorder or Injury.

There was a registered manager in post who was also the nominated individual.

The service provided intensive day care for patients with a primary diagnosis of an eating disorder. Patients accessed the service either as an alternative to inpatient treatment or as a step down from inpatient care.

The service provided individual key working, nutritional rehabilitation, a group programme, meal support, individual therapy, physical health monitoring and patients had regular reviews by the specialist eating disorder psychiatrist which included a review of medicines.

This is the first inspection of the ABBI clinic.

What people who use the service say

Prior to the inspection, CQC received six compliments about the service and one concern about the service regarding lack of exposure to fear foods and lack of staff support to access the local community to eat out.

During the inspection we spoke with six patients. Patients told us the service was different than any other treatment they had experienced. Patients said they were the most hopeful they had ever been about their recovery.

Patients said the service was very person centred, staff remembered information about them, were interested in their wellbeing and they felt valued and listened to.

Patients said the treatment model worked well, with the group work, one to one and a full multidisciplinary team to contribute. Support was also provided virtually in between sessions via WhatsApp, which patients valued.

Patients told us they appreciated the quiet room that was available for them to use in the service which they accessed if they felt overwhelmed, the room included a variety of self-soothe boxes.

Patients said they felt the building was welcoming and blended into the local community which they liked, it did not represent a hospital or clinical setting. However, the building was not accessible if you had mobility needs, as there were steep stairs and a step down into the kitchen and bathroom. The furniture did not provide the support that some people needed.

Suggestions for improvement included patients having more information about what to expect before joining the service. Also, more information in written form as patients told us they found it easier to follow written information.

Patients who attended one day a week, told us it was difficult to access the group support from the dietician and occupational therapist due to the timings of the group. They would also like to access the local community with support, however staffing levels have meant this had not happened.

Summary of this inspection

How we carried out this inspection

The inspection team comprised a CQC inspector and a specialist advisor.

Prior to and following the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information including commissioners and advocates.

During the inspection visit, the inspection team;

• visited the service, looked at the quality of the environment and observed how staff were

caring for people

•observed two group sessions

• spoke with the registered manager who was also the nominated individual

• spoke with four other staff members; dietician, registered nurse, doctor and occupational therapist

• received feedback about the service from two commissioners

• reviewed six care and treatment records of patients including care plans, risk assessments and documentation

• reviewed eight staff files

• looked at a range of policies, procedures and other documents relating to the running of the service.

This inspection was short notice announced to ensure there was someone at the service, and covered all key questions.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that the building is accessible for people with mobility needs and meets the Equality Act 2010 requirements. (Regulation 17)
- The service must ensure that the policies reflect their service and their role in relation to the Mental Capacity Act and the requirements of submitting notifications to CQC. (Regulation 17)
- The service must ensure that records are accurate, complete and contemporaneous. (Regulation 17)

Summary of this inspection

- The service must ensure that it meets the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Regulation 17)

Action the service SHOULD take to improve:

- The service should review the care records to ensure that risk management plans are easily identifiable.
- The service should ensure that an environmental risk assessment of the building is completed and shared with staff so that they are aware of any risks and how to mitigate these.
- The service should review the multidisciplinary review process and handover process to ensure all disciplines are involved and up to date with patient progress.
- The service should ensure that they follow the complaints policy by completing the complaints and compliments register.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Specialist eating disorder services

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

Is the service safe?

Good

We rated it as requires improvement.

Safe and clean environment

All clinical premises where patients received care were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Staff completed and regularly updated thorough risk assessments of all areas and removed or reduced any risks they identified. There was an environmental policy in place, however this focused on the impact of the service on the environment. The registered manager told us that an external company were in the process of creating an environmental risk assessment of the building. There was a completed fire risk assessment, by an external company, with actions relating to alarms, fire extinguishers, fire doors and an emergency plan. These actions had been completed. The electrical report including portable appliance testing was up to date. The gas and boiler checks were up to date.

The service was based in a terraced house. Downstairs there was a through room of lounge and dining space where groups took place and patients were provided with meal support. There was a kitchen where patients prepared their meals and snacks. Upstairs there were two rooms for therapy and one to one meetings and a bathroom. The building was not accessible for people with mobility difficulties. There were two steps to enter the premises, a step down into the bathroom and kitchen and a steep staircase with a handrail on one side. This did not meet the Equality Act 2010. The registered manager said there was a ramp for access to the building however this was not stored at the service. The registered manager had explored adding a downstairs toilet however this would make the kitchen smaller. There was a patient with mobility needs at the service and they told us it was difficult to access the upstairs in the building. This meant the service had not made reasonable adjustments to meet all patients' needs.

Our tour of the service showed that all areas were clean, well maintained, and well-furnished.

Staff followed infection control guidelines, including handwashing. Audits took place to monitor this.

Staff made sure equipment was well maintained, clean and in working order. The weighing scales had been calibrated.

Good

Specialist eating disorder services

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients in the service was not too high to prevent staff from mostly giving each patient the time they needed.

The team comprised the consultant psychiatrist who was also the registered manager and nominated individual, a full time mental health nurse, two occupational therapists, a dietician, a speciality doctor and a counselling psychologist who were self-employed and worked at the service on a sessional basis. There was an administrator who was employed on a part time basis.

There were plans for an additional mental health nurse to start at the service to enable more community access to take place and so that nurses could provide cover for each other. The occupational therapists covered for each other and, if off, the dietician changed their session times. The consultant psychiatrist covered for the speciality doctor if they were off. The counselling psychologist was new to the team and just developing their input into the service.

There were plans to employ a health care assistant to enhance the team and a long term aim of having a registered manager who was independent of the nominated individual.

Sickness levels were low with three cancelled sessions in the last 12 months.

Mandatory training

Staff had completed and kept up –to date with their mandatory training. The majority of staff worked elsewhere and had completed the training with their substantive employer. They shared their training evidence with the service.

The mandatory training programme was comprehensive and met the needs of patients and staff. This included basic life support, fire safety, infection control, Mental Capacity Act, data protection, health and safety, autism, learning disability and safeguarding.

The manager monitored mandatory training and alerted staff when they needed to update their training. There was a training audit in place and when courses were due for renewal the registered manager prompted staff.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They responded promptly to sudden deterioration in a patient's health. When necessary, staff worked with patients and their families and carers to develop crisis plans. Staff followed good personal safety protocols.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, this was a risk assessment created by the service, and they reviewed this regularly. The risk assessments did not include risk management plans, however the interventions that would be provided and how staff would mitigate the risk were included in other sections of the records.

All care records we reviewed included crisis plans which had been created jointly with the patients, often the patient would complete the document. This meant patients were involved in their recovery and plans.

Good

Specialist eating disorder services

Management of patient risk

Staff responded promptly to any sudden deterioration in a patient's health. Patients had one to one meetings weekly with the mental health nurse and a review by the speciality doctor fortnightly. Changes were shared with colleagues, and we saw that meetings took place with patients and family members to discuss challenges and agree a way forward.

Staff mostly followed clear personal safety protocols, including for lone working. The service had a lone working policy and risk assessment in place.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. This was mainly through their substantive employers.

Staff kept up to date with their safeguarding training. Copies of training completion were stored in staff files.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Examples included liaising with other service providers to ensure patients were kept safe and free from harm.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Staff kept records of patients' care and treatment. Records were mainly up to date and easily available to all staff providing care.

Patient notes were on paper and stored securely in a locked cupboard at the service. All staff at the service could access them easily.

We reviewed six care records. The daily notes were written on lined paper, the organisation was not identified and there was no space to log the discipline of the staff completing the records. This meant there was no reference to the organisation that the records were for.

Patient self assessments and screening tools did not include names of patients and there was no identifier, therefore you did not know if they were completed for the correct person, if files were accidentally opened, you would not know whose records they were. There were crisis plans and risk assessments without names on.

This meant the files were not all complete and contemporaneous.

The service had a record keeping policy and procedure, however this referred to staff having smartcards for electronic records, this was not the case, and the policy did not fully reflect the service.

Medicines management

The service did not prescribe any medicines. Following review, recommendations were made to patient's GPs for them to consider prescribing.

Good

Specialist eating disorder services

Track record on safety

The service had a good track record on safety.

There had not been any significant incidents at the service.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. The service had an accident and incident reporting policy. This policy did not include timescales of investigations. This meant the people involved in the incident or accident would not have an expected timescale for investigation and outcome.

There was a serious incident notification policy and procedure in place. However, this was not current, and it did not specify that notifications including death of a person using the service would come to CQC. The policy referenced 'reg authority'.

There was a structure for adverse incident review meetings to take place, this included date and time, what happened, patients views, MDT views, what did we do, what else could we have done, lessons learnt, have we shared this with anyone.

There were no incidents or accidents that had occurred within the service.

Staff understood the duty of candour and the level of incident that met the threshold however they had not had any incidents which met the threshold.

Staff met to discuss the feedback and look at improvements to patient care. We saw this within the clinical governance meeting minutes.

Is the service effective?

Good

We rated it as good.

Assessment of needs and planning of care

Staff assessed the mental health needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.

Staff completed a comprehensive mental health assessment of each patient. The consultant psychiatrist assessed all patients prior to joining the service. Once admitted to the service, the mental health nurse alongside the patient completed the risk assessment and care plan.

Staff made sure that patients had a full physical health assessment, and they knew about any physical health problems. The speciality doctor completed a review of patients, they requested bloods and ECGs via the GP. The speciality doctor then reviewed patients every two weeks and sent updates to the patient's GP.

Staff mostly developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were individualised. We reviewed six care records. Two care plans did not include the detail of how to support a specific need, for example a patient had low potassium, and another had heart arrythmia, but their care plans did not state what support should be provided. When we spoke with the individual members of the multidisciplinary team, they were all very experienced and knowledgeable in supporting people with an eating disorder and knew the support to be provided, however this was not documented in these two records in detail. This meant new staff working in the service or external people reviewing the records would not have the level of detail of interventions which should be provided.

Care plans were personalised, holistic and recovery orientated. Care plans included identified needs, patient goals, staff goals for you, interventions and patient's views. The patient's views were handwritten sections completed by patients which showed clear patient co-production.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.

Staff provided a range of care and treatment suitable for the patients in the service. There were group sessions facilitated by the mental health nurse, one to one reviews with the consultant psychiatrist and speciality doctor and one to one and group sessions facilitated by the dietician and occupational therapist. Recently a counselling psychologist had joined the team to offer group sessions.

Staff delivered care in line with best practice and national guidance. The group work was based on MANTRA which is a specialist therapy for the treatment of eating disorders. MANTRA aims to help patients find alternative and more adaptive ways of coping. There were two groups being facilitated; one for patients with anorexia nervosa or bulimia and one for patients with a binge eating disorder. This approach alongside the multidisciplinary provision including the nutritional support met the recommendations of the NICE guidance NG69 Eating disorders: recognition and treatment, which services providing care to people with an eating disorder should follow in line with best practice guidance.

Staff made sure patients had support for their physical health needs, from their GP. The speciality doctor was the main link with the GP. They provided regular updates and a discharge summary at the end of treatment.

Staff used recognised rating scales to assess and record the severity of patient conditions and care and treatment outcomes. At admission patients completed the outcome measures and these were reviewed at week four, eight and 12. The outcome measures used were Clinical Impairment Assessment, DASS (Depression, Anxiety and Stress Scale), EDSIS (Eating Disorders Symptom Impact Scale), EDEQ (Eating Disorder Examination Questionnaire, PSYCHLOPS, Beck's Anxiety Inventory, Beck's Depression Inventory and Hospital Anxiety and Depression Scale. This meant the service were exploring holistically the needs of the patient and the progress they were making in their recovery.

Staff took part in clinical audits. These included patient file audits and patient experience. However, the patient file audit did not identify concerns in relation to records not having patient names and identifiers on.

Managers used results from audits to make improvements. The audits generated change including the introduction of an admission checklist.

Skilled staff to deliver care

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

The service had a full range of specialists to meet the needs of each patient. The team comprised the consultant psychiatrist who was also the registered manager and nominated individual, a full time mental health nurse, two occupational therapists, a dietician, a speciality doctor and a counselling psychologist who were self-employed and worked at the service on a sessional basis. There was an administrator who was employed on a part time basis. There were plans in place to employ a further mental health nurse to support patients to access the community during their time at the service, to support their recovery as this had been difficult to accommodate to date.

Managers made sure staff had the right skills, qualifications, and experience to meet the needs of the patients in their care. Records showed all staff had experience and knowledge of working with people with an eating disorder.

Managers gave each new member of staff a full induction to the service before they started work. There was an induction policy in place and all staff had a completed induction checklist in their file.

Managers supported staff through regular, constructive appraisals of their work. There was an appraisal policy in place. For staff who worked substantively for another provider, they completed their appraisal, and the staff member shared this appraisal with the ABBI clinic.

Managers supported staff through regular, constructive clinical supervision of their work. The supervision policy stated that staff should receive one to one supervision every three months. Records showed this was happening.

Managers made sure staff attended regular team meetings and gave information to those who could not attend. Monthly meetings took place which covered clinical effectiveness, staff management and feedback, patient feedback and risk.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This was discussed in individual supervision and team meetings.

Managers made sure staff received any specialist training for their role. The mental health nurse had attended ARFID (Avoidant restrictive food intake disorder) training and had shared the information with the wider team. Staff were in the process of completing CBT-E training (enhanced cognitive behaviour therapy developed for patients with an eating disorder).

Managers recognised poor performance, could identify the reasons and dealt with these. This was discussed through staff supervision and one to one meetings.

Good

Specialist eating disorder services

Multidisciplinary and interagency teamwork

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. However, these meetings were held with the speciality doctor and the patient, other members of the multidisciplinary team provided their feedback via the multidisciplinary document. Not all team members worked on the same day, this meant the review was not multidisciplinary in person.

Staff made sure they shared clear information about patients and any changes in their care, including during transfer of care. However, this was not always recorded within the care record and there was no handover document in place. Staff had a secure WhatsApp group to anonymously update on patients. Staff recorded their input in different sections of the file and not all documents had patient names on which meant it was difficult to identify the current multidisciplinary opinion of the patient.

Staff had effective working relationships with external teams and organisations, including community eating disorder teams.

Good practice in applying the Mental Capacity Act

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

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a Mental Capacity Act policy and procedure, this included the service's response if they were concerned about a patient's capacity and the process of acting in their best interests.

Staff knew where to get accurate advice on Mental Capacity Act.

Staff assumed and recorded capacity to consent for the participation in the group sessions within the daily records.

The service did not monitor how well it followed the Mental Capacity Act and did not have any examples where they made changes to practice when necessary.

Staff did not audit how they applied the Mental Capacity Act.

Is the service caring?

Good

We rated it as good.

Good

Specialist eating disorder services

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it. We observed two group therapy activities, staff were responsive to the individual patient needs and encouraged patent participation in the group and valued their contribution.

Staff supported patients to understand and manage their own care treatment or condition. Patients told us that they had regular one to one meetings with the nurse, speciality doctor and consultant psychiatrist, this allowed them to share their views and update on their progress. One to one sessions took place with the dietician to enable a joint meal plan to be developed. The plans were individualised and tailored to patients, with manageable goals.

Patients said staff treated them well and behaved kindly. Patients were overwhelmingly positive about staff and how the service valued them as an individual and tailored the service accordingly.

Staff understood and respected the individual needs of each patient. Individual interviews with staff and patients confirmed this.

Staff told us they felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and staff.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.

Involvement of patients

Staff involved patients and gave them access to their care plans. We reviewed six care records. Patients co-produced their crisis plans and these were usually written by patients. Care plans had a section for patient comments, this section was written by patients.

Staff made sure patients understood their care and treatment. Patients told us the combination treatment of group work and one to one support was helpful as there was both peer support and the opportunity to explore their treatment individually with professionals.

Staff involved patients in decisions about the service, when appropriate. Minutes of the patient participation group showed patient involvement in the group therapy session content, the equipment in the building, the patient feedback form and staff interview questions. Changes were made following patient feedback.

Patients could give feedback on the service and their treatment and staff supported them to do this. Feedback methods included a monthly feedback sheet, a suggestions box and a patient participation group.

Although the service did not have access to advocacy services, the registered manager was exploring this.

Good

Specialist eating disorder services

Staff informed and involved families and carers appropriately. Records showed meetings took place with families where required.

Involvement of families and carers

Staff supported, informed and involved families or carers. There was a family support checklist in place which staff worked through, this included offering a family session and also links to external support. Records showed meetings took place with families and the service was responsive when family members gave feedback about the service, changes included introducing the weekly family sessions.

Staff helped families to give feedback on the service. This was encouraged via email, in person or feedback forms. There was a family, guardian, carer and friend welcome pack, which included what to expect from the service and the support for families including progress updates if patients consented.

Is the service responsive?

Good

We rated it as good.

Access and waiting times

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care.

The service had clear criteria to describe which patients they would offer services to. There was a service user guide and welcome pack which explained the service and what to expect. The website included the referral process. Once assessed if the service could meet the person's needs and funding was in place, there was no waiting list and patients could join the existing service.

Staff tried to engage with people who found it difficult, or were reluctant, to seek support from mental health services. This included patients having the option to join the groups remotely.

Staff tried to contact people who did not attend appointments and offer support. Records showed that staff tried to explore the reason why someone was not attending the service and arranged to meet with them and agree next steps.

Patients had some flexibility and choice in the appointment times available. Day care sessions took place two days per week, and these were a morning into afternoon session or an afternoon into evening session. Patients chose the sessions that worked best for them. Patients told us the session times enabled them to work half a day and minimise the impact of treatment on their work.

Sessions ran on time. There was a gap in between sessions to enable a break and avoid a cross over of groups.

The service used systems to help them monitor referrals. There was administrative support who coordinated the initial assessment appointment. If accepted into the service, the specialist nurse arranged for the patient to visit the service prior to joining the group.

Good

Specialist eating disorder services

Staff supported patients when they were referred, transferred between services, or needed physical health care. Liaison took place with external teams including community teams and GPs.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

The service had a full range of rooms and equipment to support treatment and care. The service was based in a terraced house and the sessions took place in rooms that were homely and welcoming with soft furnishings, a choice of seating and space for people to go to if they needed time out of the session was available. There was a quiet room with a variety of self-soothe boxes, which contained items that people may find relaxing and reassuring, including sensory items. Patients talked positively about this room and the opportunity to have a break if needed, self-regulate and, when ready, return to the group.

Interview rooms in the service did not have sound proofing. However, the groups were small in number, this meant that there would only be one one to one meeting taking place upstairs whilst the group continued downstairs, this protected patient's privacy and confidentiality.

Meeting the needs of all people who use the service

The service met the needs of most patients – including those with a protected characteristic.

The service could support and make adjustments for people with certain disabilities, communication needs or other specific needs. The service had developed a management of patients with an eating disorder and autism spectrum condition document. This included best practice guidance. Reasonable adjustments included a plan for the day on the white board to help patients know what was happening next. The welcome pack included photographs of the staff team that patients would be meeting.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. This was included in the welcome pack and there was a feedback box at the service.

The service did not provide information in a variety of accessible formats so the patients could understand more easily. However, staff told us, if this was required for any patient this could be arranged.

The service did not have information leaflets available in languages other than English, however staff told us this could be accessed if needed.

Managers made sure staff and patients could get hold of interpreters or signers when needed. Managers had identified a service to provide this if needed.

Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns. Information was included in the welcome pack and there was information on display at the service, including a feedback box. Patients were also encouraged to give feedback via the feedback forms and attending the patient participation group.

Good

Specialist eating disorder services

Staff understood the policy on complaints and knew how to handle them. There was a complaints policy which included timescales of the complaints investigation process.

Staff knew how to acknowledge complaints, however there was no clear process in place of ensuring that the complaint and feedback was recorded and acted upon. There was a word document with the month and year that the feedback was received, and the action taken. There was also a feedback file, however there was no record about which patient the feedback was from. The complaints and compliments register in the complaints policy had not been completed. This meant there was no oversight of the feedback to the service in a central place.

There had not been any formal complaints to the service.

Managers shared feedback from complaints with staff and learning was used to improve the service. Patient feedback was a standard agenda item in the clinical governance meetings, minutes showed feedback discussed and agreed actions for the team.

The service used compliments to learn, celebrate success and improve the quality of care. The service had received nine compliments and CQC received six compliments about the service. Feedback was shared with staff at the clinical governance meetings.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

Leadership

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

Leaders provided clinical leadership. The medical director was the nominated individual and consultant psychiatrist. They were visible in the service and knew the patients. They facilitated the monthly meetings and clinical governance meetings.

Leaders had the skills, knowledge and clinical experience to perform their roles. However, managing staff and the processes regarding this were new to the registered manager, as previously they had worked for larger organisations where there was more corporate support. This meant some of the processes were still in their infancy.

The organisation has a clear definition of recovery, and this was shared and understood by all staff. The structured day care approach focused on recovery and skill development and coping mechanisms for patients.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. Patients and staff told us how visible, supportive and approachable they were.

Good

Specialist eating disorder services

Vision and strategy

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

Staff knew and understood the vision and values of the team and organisation and what their role was in achieving that.

All staff did not have a job description, as they were self-employed. There was one employed full time member of staff. The registered manager was in the process of ensuring their employment needs were met including access to training.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Minutes showed that discussions took place within the monthly meetings and clinical governance meetings.

Staff could explain how they were working to deliver high quality care within the budgets available. Staff were very passionate about their role and the service, records showed patient attendance at groups facilitated by the dietician and occupational therapist. Staff attended external forums and peer groups to share best practice.

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development. They could raise any concerns without fear.

Staff felt respected, supported and valued. Staff feedback questionnaires had been completed and these were positive, staff talked about the team support and multidisciplinary working. The only areas for improvement suggested was the introduction of electronic care records.

The service had a staff group that felt positive, satisfied and had low levels of stress. Staff told us and records showed that staff felt supported and listened to.

Staff felt valued and part of the organisation's future direction. Minutes showed and staff told us that they discussed service development at regular meetings and informally between the meetings.

Staff felt positive and proud about working for the provider and their team. All staff we spoke with were extremely positive about the service and the outcome for patients. They felt the service was valued and an essential part of patients recovery.

There was no health screening in place for staff, to identify any areas for reasonable adjustments. Staff did have access to support for their own physical and emotional health needs through an occupational health service.

Within supervision, the registered manager monitored morale and job satisfaction.

Staff reported that the provider promoted equality and diversity in its day to day work. There was documentation about equality of access to the service.

The team worked well together and, where there were difficulties in staff relationships, managers dealt with them appropriately.

Good

Specialist eating disorder services

Governance

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

Some policies, procedures and protocols did not reflect the service. They were aimed at GP practices and had not been fully tailored or implemented in the service. There was an environmental policy in place, however this focused on the impact of the service on the environment. The registered manager told us that an external company were in the process of creating an environmental risk assessment of the building. This was not in place at the time of the inspection.

The service had a record keeping policy and procedure however this referred to staff having smartcards for electronic records, this was not the case, and the policy did not fully reflect the service.

The service had an accident and incident reporting policy. This policy did not include timescales of investigations. This meant the people involved in the incident or accident would not have an expected timescale for investigation and outcome.

Staff records did not meet schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed eight staff files. None had health screening information in them, and four out of eight staff records did not have a full work history.

There were set agendas for the clinical governance and monthly meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The clinical governance meeting agenda included; risk management, clinical effectiveness and research, audit, patient involvement and feedback, information and IT, staff management and education and training. The agenda for the monthly meeting included; clinical effectiveness, staff management and feedback, patient feedback and risk.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. These included the introduction of the welcome pack and self-soothe boxes and support for families and carers. However, feedback from patients about wanting to access the local community more for food exposure, accessing cafés and shops had not been met due to staffing levels.

Staff undertook or participated in local clinical audits. The audits were not sufficient to provide assurance, as the patient file audit did not identify concerns in relation to records not having patient names and identifiers on. However, we did see examples of staff acting on other results of the file audit, including missing documentation when needed.

Data and notifications were submitted to external bodies. Statutory notifications were submitted to CQC.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients.

The service had a whistle blowing policy in place which staff were aware of.

Management of risk, issues and performance

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

Staff maintained and had access to the risk register. Staff could escalate concerns when required. There was a risk management policy and procedure and risk register in place. Risks were staffing, commissioning and electronic care records.

Staff concerns matched those on the risk register. Staff told us and feedback forms corroborated the risks on the risk register.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

The service monitored sickness and absence rates.

When the location was registered there was a virtual site visit on 23 June 2021, during this, the registered manager said that the building was accessible to wheelchair users, activities could take place downstairs and that they would put an accessible toilet in. During the inspection we noted two steps to get into the building. The ramp was not there. There were steep stairs that had a handrail on one side. There was a step down into the bathroom and kitchen with no warning signs for people. When asked the registered manager said there was a ramp, but they did not keep it on site all the time. Also, they had looked at putting a downstairs toilet in but that would mean they would lose the fridge freezer, they were looking at alternative venues if the service expands in future. The service did not meet the Equality Act 2010: "A service provider must take such steps as it is reasonable to take to avoid putting disabled people at a substantial disadvantage caused by a physical feature." This meant the service had not completed what was agreed at registration and had not made the building accessible. The registered manager told us they were exploring alternative locations for the service which were accessible and could accommodate the potential growth of the service.

Information management

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

The service used systems to collect data from patients at admission to the service and then this was repeated throughout treatment.

Staff had access to the equipment and information technology needed to do their work. Staff told us there were plans to introduce electronic care records. Care records were paper. We reviewed six care records. The daily notes were written on lined paper, the organisation was not identified and there was no space to log the discipline of the staff completing the records. This meant there was no reference to the organisation that the records were for.

Patient self-assessments and screening tools did not include names of patients and there was no identifier, therefore you did not know if they were completed for the correct person, if files were accidentally opened, you would not know whose records they were. There were crisis plans and risk assessments without names on. This meant records were not accurate, complete and contemporaneous.

Staff made notifications to external bodies as needed. Notifications to CQC had been received in relation to safeguarding.

All information needed to deliver care was stored securely and available to staff, in an accessible form, when they needed it. Records were stored in a locked cupboard.

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The service ensured service confidentiality agreements were clearly explained including in relation to the sharing of information and data. This was included in the patient welcome pack.

Engagement

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

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet and patient feedback and family sessions.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. These included feedback forms, one to one opportunities and patient participation group.

Learning, continuous improvement and innovation

The organisation encouraged creativity and innovation to ensure up to date evidence-based practice is implemented and imbedded. The specialist nurse had completed their ARFID (Avoidant restrictive food intake disorder) training and had shared their learning with the wider team.

The registered manager was part of the provider collaborative clinical delivery group for eating disorder services. They had contact with the lead for eating disorders at the Royal College of Psychiatrists. They had also set up a day care providers forum where services share best practice and learning.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We reviewed six care records. The daily notes were written on lined paper, the organisation was not identified and there was no space to log the discipline of the staff completing the records. This meant there was no reference to the organisation that the records were for. Patient self assessments and screening tools did not include names of patients and there was no identifier, therefore you did not know if they were completed for the correct person, if files accidentally opened, you would not know whose records they were. There were crisis plans and risk assessments without names on. We reviewed 8 staff files. None had health screening information in them. Four staff records did not include a full work history. Staff records did not meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was not accessible to wheelchair users, the registered manager advised as part of the registration they would install an accessible toilet, this has not been completed. Policies did not always reflect the service being provided.