Oak Tree Forest Ltd. t/a Ellern Mede Ridgeway

Quality Report

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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?	Good
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.

Summary of findings

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.

Overall summary

We rated the service as good because:

- The service had addressed several areas of concern since the last inspection in March 2016. This included having sufficient emergency resuscitation equipment that staff checked regularly, ensuring staff accessed monthly individual supervision, and ensuring compliance with mandatory training in safeguarding, breakaway and physical intervention. The service had also reviewed and improved their processes for responding to complaints. Patient bedrooms now had wall alarms so patients could more easily alert staff if needed.
- Patients gave positive feedback about most staff and said they felt their individual needs were met. Parents gave very positive feedback about the service and felt very involved in their child's care.
- Staff carried out timely and comprehensive assessments of physical and mental health needs and risks for each patient and developed care plans to meet these needs. Staff updated risks assessments and care plans regularly.
- Some patients care involved physical restraint during naso gastric feeding. The service had developed a written tool to be able to include the patient in the planning of this. This was to ensure the patient had as much involvement in their care as possible. The service was also involved in the re-design of a chair for naso gastric feeding that could be used nationally.
- There were effective governance processes in place. Staff knew how to report incidents and learning was disseminated and discussed at ward level. The service carried out regular audits and senior staff met regularly to review the running of the service.
- The service were committed to and involved in several pieces of work in quality improvement and innovation.

However:

- Although patients were involved in giving feedback about their care, several said they would like to see or keep copies of care plans and would like to be involved in developing them from the start.
- Patients said some staff were impatient with them and inconsistent in how they enforced rules.
- Patients said food was not as well prepared on the weekends compared to weekdays.
- Space on the wards and in the cottages was limited. As patients shared bedrooms and bathrooms, there was a lack of private space.
- There were limited activities available on the weekend. Male patients said they would like more sports activities to engage in.

Summary of findings

Contents

Good

Oak Tree Forest Ltd. t/a Ellern Mede Ridgeway

Services we looked at:
Specialist eating disorders services

Summary of this inspection

Our inspection team

The team comprised two CQC inspectors, two specialist advisors who were nurses with experience in working in eating disorder services, and one expert by experience. An expert by experience is someone who has experience using a service or caring for someone who has.

Why we carried out this inspection

We undertook this inspection to find out if Oak Tree Forest Limited had made improvements to this service since our last inspection in March 2016.

When we last inspected this service we issued four requirement notices and outlined seven areas the service needed to improve. These improvement were to ensure that:

- Privacy for patients was upheld during physical intervention.
- Patient information was stored confidentially.
- Staff could access emergency equipment quickly, that it was within date and regularly checked.
- Staff routinely checked fridge temperatures in line with infection control standards.
- Mandatory training rated improved.
- Governance systems ensured the service was effectively assessed and monitored.
- Staff handled and responded to complaints appropriately.

This related to the following regulation under the Health and Social Care Act (Regulated Activities)

Regulations 2014:

- Regulation 10: Dignity and respect
- Regulation 12: Safe care and treatment
- Regulation 17: Good governance
- Regulation 16: Receiving and acting on complaints

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited the two wards and cottage and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 13 patients who were using the service
- spoke with six parents who had children using the service
- spoke with nurse in charge for each of the wards
- spoke with 15 other staff members; including doctors, nurses, healthcare assistants and social workers
- attended and observed a multidisciplinary meeting
- looked at six treatment records and six medication charts of patients
- carried out a specific check of the medication management

Summary of this inspection

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

Information about Oak Tree Forest Ltd. t/a Ellern Mede Ridgeway

Ellern Mede Ridgeway is a hospital run by Oak Tree Forest Limited. It is registered to provide 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 a high dependency, intensive treatment for patients with highly complex eating disorders and can support patients with naso gastric feeding. Nunn Ward has 12 beds and provides a recovery focussed programme for patients who are stabilised and require ongoing support. The cottages have space for three female and three male 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 NHSE patients and five beds for non-NHSE patients. At the time of inspection, there were 13 patients aged 15 and under and 14 patients aged between 16 and 18.

The hospital has a school on-site equipped to meet patients' educational needs. Ofsted rated the school as outstanding in 2014.

Ellern Mede Ridgeway has a registered manager and undertakes the following registered activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment, for persons detained under the Mental Health Act 1983

Since 2012 we have inspected the service five times.

What people who use the service say

Patients gave a lot of positive feedback about staff. They said staff treated patients as individuals and were enthusiastic and most staff were kind and caring. One patient said staff came and spoke with them when they saw they were sad. A small number of staff were described as being impatient and inconsistent with ward rules at different times. Patients on Lask Ward wanted more activities.

Patients said they felt safe, staff were always visible on the wards and the wards were kept clean. Patients noted the wards were small and they could have more decoration. A small number said they did not like sharing a bedroom.

Patients said they would like to have a copy of their care plan.

Patients gave positive feedback about the school. They said the teachers were very nice, they gave them space and they learnt a lot with their support.

Patients were aware of the advocacy service and ways they could give feedback about the service.

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?

Good

We rated safe as good because:

- Staff assessed the risks for each patient on admission and regularly thereafter.
- There was medical cover during the day and night. A doctor could attend the ward quickly in an emergency.
- Staff managed medicines appropriately.
- Staff could access emergency resuscitation equipment. Staff checked this equipment regularly and replaced expired items.
- The service had effective processes to ensure the environment was compliant with infection control standards and reviewed the environmental regularly for hazards.
- Since the last inspection the service installed wall alarms in patient bedrooms inspection so patients could more easily alert staff if needed.
- Since the last inspection compliance with mandatory training had improved and average compliance was 87%.
- Staff used physical restraint only when verbal de-escalation was not effective or where this was part of the naso gastric feeding plan. The service included the patient in the planning of physical intervention during naso gastric feeding using an internally developed document.
- There was an effective system in place to report and learn from incidents.

However:

- Staff did not always record their one-to-one sessions with patients in notes.

Are services effective?

Good

We rated effective as good because:

- Staff completed comprehensive assessments for each patient and created detailed, personalised care plans.
- Staff assessed and supported patients with physical health needs.
- The service followed national guidance when prescribing medication and offered nationally recommended psychological therapies.
- Staff received regular one to one supervision and could access group supervision. This had improved since the last inspection in March 2016.

However:

Summary of this inspection

- Staff did not always store assessments of patient capacity and Gillick competence clearly in patient notes, meaning they were hard to locate.

Are services caring?

Good

We rated caring as good because:

- Patients said most staff were kind and caring.
- Parents gave very positive feedback about the service and described staff as dedicated. They said staff identified the individual needs of their child and supported them well.
- Patients had access to advocacy services.
- Staff involved families in care. The service ran a monthly parents group for peer support and sharing information about eating disorders and its treatment.
- Patients attended weekly community meetings where they could give feedback about the service. Staff discussed this feedback in weekly governance meetings.

However:

- Some patients said there were a few staff who were impatient and inconsistent with rules.
- Staff developed care plans for patients then shared these with them to get their feedback. Although patients were involved in giving feedback about their care, several said they wanted more involvement from the start and would like to see or keep copies of the care plans.

Are services responsive?

Good

We rated responsive as good because:

- Since the last inspection, the service reviewed its complaints procedure and now logged and responded to complaints within set timescales. Patients and families were aware of how to give feedback. This feedback was regularly discussed and considered by senior staff.
- Patients could access mobile phones and could make calls in private.
- Patients said the food was of good quality during the week, but it wasn't as well prepared on the weekends. Menus addressed cultural and religious needs as well as any allergies.

However:

- Space on the wards and in the cottages was limited and patients shared bedrooms and bathrooms. This meant there was a lack of private space. There was not enough seating for all patients in the lounge on Nunn Ward.

Summary of this inspection

- There was an activities timetable for the week, but patients said there were limited activities on the weekend. Patients on Lask Ward said there could be more activities offered in general. Male patients said they didn't enjoy the range of sports activities available and would like different sports offered.

Are services well-led?

Good

We rated well led as good because:

- The service had clear clinical governance structures and processes in place. Since the last inspection in March 2016, the service had addressed several concerns, such as supervision and mandatory training rates in specific areas.
- The service had a risk register that staff used effectively to address risks highlighted internally or externally.
- Staff were positive about their teams and the support they received from colleagues and managers.
- The service was committed to quality improvement and innovation through membership in peer review networks and involvement in the development of national research, guidelines and training.
- Staff and patients were aware of the most senior managers in the organisation and these staff visited wards regularly.
- The service carried out regular clinical audits and used a range of recognised outcome measurements.
- The organisation offered several bursaries and placements for staff wishing to access further training.
- Staff had an understanding of their responsibilities under the Duty of Candour and put this into practice.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in reaching an overall judgement about the Provider.

- Staff received training in the MHA and compliance was 85% at the time of inspection. Staff could describe how to obtain consent from patients and there was information about consent to treatment in ward areas. Administrative support and legal advice on implementation of the MHA and its code of Practice was available from a central team.
- Staff gave patients information about their rights.
- Patients could access Independent Mental Health Advocates (IMHAs), which is a legal right. IMHAs are trained within the framework of the MHA and support patients detained under the MHA to understand their rights and take part in decisions about their care.
- In one patient's notes staff had written instructions stating nurses were to apply their holding powers if the patient attempted to leave the ward. This was not appropriate, as holding powers should be considered and used in response to specific risks at that time, rather than planned.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in the Mental Capacity Act 2005 (MCA). The overall compliance rate was 87%, with 100% of doctors trained.
- Staff had an understanding of Gillick competence. Gillick competence is where a person is assessed as having the competence to make decision about their own care, without the need for parental consent.

Good

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Good

Safe and clean environment

- Although ward layouts did not allow staff to observe all parts of the ward, staff used regular observations and risk assessments to ensure risks were mitigated. Patients assessed as higher risks were observed at all times, in line with their care plans.
- Staff managed ligature risks present on the wards and in the cottages through regular observation and individual risk assessment. Patients only accessed high risk areas, such as kitchens, when supervised. Ligature risk assessments of the two wards identified risks and action plans outlined how staff should manage these. The most recent assessments identified 29 pieces of maintenance work needed across the wards, with a completion date of March 2017 stated on an action plan. Several of the 29 items were repeated issues identified in each bedroom and bathroom.
- Lask ward could accommodate male and female patients whilst complying with guidance on same sex accommodation. At the last inspection in March 2016, there was no female only lounge available on Lask Ward. At this inspection, a female only lounge was available to patients.
- Each ward had a clinic room where staff stored medicines, including basic emergency medicines, appropriately. Equipment to check patients' weight, blood pressure, pulse and temperature were available. This equipment was calibrated, which means it had been serviced to ensure it gives accurate readings. Clinic rooms had lockable medicines fridges and staff kept daily records of the temperatures as required.
- Staff on each ward and in the cottages could access emergency resuscitation equipment in a timely way. Lask Ward had emergency resuscitation equipment in the clinic room. Staff on Nunn Ward and in the cottages could access emergency resuscitation equipment from the reception area of the hospital. At the last inspection in March 2016, we found that staff did not record regular checks of emergency equipment and an out of date face mask had not been replaced in the emergency oxygen bag on Lask Ward. During this inspection, this was no longer an issue. Records showed staff checked emergency equipment regularly and all equipment was within date.
- Ligature cutters were visible in staff areas on each ward, staff knew where they were and there were signs indicating their location. Incident reports showed staff knew where these were and how to use them in an emergency. In 2016, staff reported 32 incidents where patients attempted to use a ligature to harm themselves by tying something around a part of their body. Staff could describe recent incidents and learning from these.
- There was a first aid box available in the reception area. Contents were all within date.
- Ward and office areas were visibly clean. Cleaning records were available and outlined the regular cleaning tasks that domestic staff carried out. Patients, staff and

parents said the general environment was always kept clean. Three patients on Nunn Ward and one on Lask Ward said bins in bathrooms did not get emptied regularly enough and they overflowed.

- Staff completed annual infection control audits to ensure the environment and staff were compliant with infection control standards and principles. The most recent audit, from June 2016, showed staff identified nine actions as necessary and eight of these were marked as complete. Senior staff explained action was ongoing for the one outstanding item, but this was not written on the audit document. There were posters about handwashing available throughout the service. At the last inspection in March 2016, we found that staff did not regularly check the temperature of the fridge in the occupational therapy kitchen. Staff now did this regularly.
- Estates staff carried out daily, weekly and monthly checks of the physical environment and did repairs where necessary. Detailed records were available for identified issues and work to address them.
- At the last inspection in March 2016, we identified that there was no way for patients to raise an alarm from their bedroom other than shouting for staff attention. During this inspection, we saw a wall alarm system was installed in communal areas and bedrooms to allow patients and staff to raise an alarm. The system was not yet in full use and staff needed to travel to the alarm panel in the nurses' office to identify where the alarm was raised from. Staff said they would be receiving hand held alarms to identify alarms. Patients and staff we spoke with said they felt safe on the wards.
- The service complied with fire safety guidance. There were fire extinguishers placed throughout the wards and fire evacuation procedure notices contained the relevant information about an assembly point. Staff could describe how to carry out an evacuation, completed weekly fire drills and carried out regular fire risk assessments.

Safe staffing

- The provider calculated a minimum number of staff required for each ward and in the cottages daily, depending on the number, need and risk of patients. On the wards during the day time, the requirement was at least two qualified nurses. Numbers of healthcare assistants ranged from two to seven, depending on observation levels. During the night, the requirement was at least one qualified nurse and between two and eight healthcare assistants. The provider met required staffing levels for most shifts, but on some shifts the wards only had one nurse working. Nunn ward had the highest numbers of shifts where only one nurse was working: 13% between November 2016 and February 2017. For 92% of these unfilled shifts, the provider employed up to four additional healthcare assistants on the ward to safely meet the need of patients.
- The service used bank and agency staff appropriately to fill shifts. The use of bank and agency nurses was below 3% between November 2016 and February 2017. The most frequent use of agency staff was on Lask Ward, with 30% of shifts filled by agency healthcare assistants employed to carry out one-to-one observations and planned physical intervention. These staff received specific training to carry out these roles.
- There were enough staff employed so that patients could have regular one-to-one time with their named nurse. However, staff recording of fortnightly one-to-one sessions with patients varied. For four of six patients staff recorded these meetings regularly, but for two patients recording was not present or infrequent. For these two patients, informal contact with staff was recorded.
- Staff were trained to carry out physical interventions, including physical intervention during naso gastric feeding.
- There was adequate medical cover during the day and night and a doctor could attend the ward quickly in an emergency.
- The service provided mandatory training in 17 areas and overall compliance was 87%. Some of the training courses were specific to certain groups. For example, only nursing staff who carried out naso gastric feeding where trained in how to do this. At the last inspection in March 2016, we found several areas of poor compliance, such as breakaway training, physical intervention and safeguarding. During this inspection, compliance rates in these areas were between 85% and 94%.
- We reviewed employment records for four members of staff. All files included an offer and outcome checklist that was completed well, showing the service followed

required processes. All necessary documents, such as references and criminal record checks, were in place. Issues identified at the last inspection, where two of ten files did not contain an application form and a probationary review were, no longer identified.

Assessing and managing risk to patients and staff

- Staff assessed the risks for each patient when they were admitted and re-assessed this regularly throughout their admission. Records we looked at showed staff assessed risks on the day of admission and reassessed this every week during multidisciplinary meetings. On risk assessment documents staff gave a narrative description of risks and allocated a rating of one to four, indicating a range from low to high.
- There were some age appropriate rules on the wards. For example, patients could access their phones outside of school time, but not during school. The unit outlined bed times for patients of different ages. Patients said they were aware of bed times, but could stay up later on occasions.
- To mitigate risks, the wards were locked and patients had to ask staff for permission to leave. Patients who were not detained under the Mental Health Act said they knew of their rights, including their right to leave the ward.
- The service used a system of different levels of observation for patients. This ranged from general observation every 15 minutes up to two members of staff observing one patient at all times. Staff reviewed this observations levels appropriately and regularly.
- Staff used physical intervention only after verbal de-escalation had failed or when this was part of the agreed plan for naso gastric feeding. Staff regularly reviewed naso gastric restraint plans to ensure this only took place when necessary. The service analysed incident data and found that in 2016 there were 48 incidents of unplanned restraint to manage aggression. Of these, 17 involved hand support only. Parents of young people who had been involved in restraint were aware of how and when restraint took place and said staff explained it. Parents said they felt involved in care plans involving planned restraint.
- The service used an internally developed tool to a plan for physical intervention, including for patients requiring naso gastric feeding. We saw staff completed this form with input from patients. The form allowed patients to be involved in the planning of any physical intervention that might take place.
- In the 12 months before the inspection, there were no incidents reported where rapid tranquilisation was used.
- Staff received training in the appropriate levels of safeguarding and could describe how to identify and report safeguarding concerns.
- There was good medicines management on the ward. Medicines were stored and dispensed appropriately. A pharmacist from an external company visited the wards weekly to audit the storage and administration of medicines. They reported any medicines errors using an online system that all senior staff could access. Where medicines errors occurred, staff reported these as an incident. The pharmacist attended the service quality committee four times a year and presented a report on medicines management from the previous three months. The pharmacist said the service acted appropriately on any feedback and reports.
- We reviewed six medicines prescription charts. These were filled in appropriately with doctor and nurse verification recorded and allergies identified.
- Staff regularly assessed the physical health needs of patients, including complications from being a low weight. Staff assessed patients for pressure ulcers on their admission to the service. This ensured they would be picked up addressed safely.

Track record on safety

- In the 12 months before the inspection there were no reported serious incidents that required investigation.

Reporting incidents and learning from when things go wrong

- At the time of inspection, the service had introduced a new system to report incidents, which all staff were aware of. It was an electronic system and it allowed staff to add detailed information about incidents. Forms for reporting physical intervention included the appropriate questions about how many and which staff

were involved, in what positions, and for how long. Staff reported 3,592 incidents of feeding via naso gastric tube in 2016. This is an average of 10 per day. Of these, 2,133 (59%) were done under a planned restraint.

- Separate to incidents involving naso gastric feeding, staff reported a total of 421 incidents in 2016. Of these, 280 (67%) involved three specific patients. Of the 421 incidents, 374 (89%) were from Lask Ward, the high dependency ward.
- Since the last inspection, senior staff made changes to the process of reporting and learning from incidents. They reviewed the incident policy and put a new reporting system in place, using forms in accordance with the Public Health Model. Senior staff viewed and discussed incidents at weekly centre operational management meetings.
- Staff discussed incidents in ward meetings and received emails that listed lessons learnt from recent incidents. Where the incident was serious, lessons learnt information was attached to payslips. The lessons learnt document was also saved onto a shared drive on the computer system that all staff could access. In the most recent staff survey in August 2016, 75% of staff that took part agreed that the organisation was committed to learning lessons.
- Staff understood their responsibilities under the duty of candour. Duty of candour is a legal requirement which means providers must be open and transparent with clients about their care and treatment. This includes a duty to be honest with clients when something goes wrong. Staff were aware of the need to be open and transparent when things went wrong.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff completed comprehensive assessments for each patient within 48 hours of their admission. Staff assessed the physical and mental health needs of patients as well as the patient's goals for treatment.
- Records showed that staff assessed and supported young people with any physical health needs and referred to specialists where necessary. Patients were not registered with a local GP, but would be assessed by the ward doctor. Records showed staff recorded daily vital signs and carried out specialist, individual physical health assessments if necessary. For example, tissue viability assessments. Records showed staff carried out electrocardiograms (ECGs) for patients who required this on admission and regularly afterwards. An ECG checks the hearts rhythm and electric activity and is important to ensure patients receive the right treatment and medicine.
- Patients had care plans to address and support their individual needs. These were detailed, personalised and recovery orientated. Examples included care plans for physical health, dietary needs and self harm. Records showed staff reviewed and updated care plans on a monthly basis.
- Staff used paper record systems and stored information securely and confidentially. At the last inspection in March 2016, we found that information about patients was visible in the nursing office from the ward area on Nunn Ward, which compromised patient confidentiality. During this inspection, the service had addressed this. Staff used a code system to display key information about patients. This meant it was still accessible, but did not compromise confidentiality.

Best practice in treatment and care

- Records showed staff followed national guidance when prescribing medication.
- The service offered nationally recommended psychological therapies for patients with an eating disorder. Therapies included cognitive behavioural therapy, family therapy and art therapy. Group therapy sessions were available and rotated every 10 to 12 weeks. Staff reviewed the therapies offered to each patient on a weekly basis at the multidisciplinary meeting, to ensure they were appropriate for their needs.
- The provider used the Royal College of Psychiatrists guidelines on the Junior 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.

- Staff used up to eight different recognised rating scales to assess and record the severity of illness and outcomes for patients. The service planned to collect these at each Care Programme Approach (CPA) from January 2017 onwards, and records showed staff were starting to embed this.
- Staff carried out 16 regular clinical audits and one staff member took the lead on clinical audit . Audits included those on care documentation, health and safety and nutrition.
- The service had an on-site school that was a registered examinations centre and was rated as Outstanding by Ofsted in 2014. Patients and parents gave very positive feedback about the school. One patient said they learnt a lot. One parent said their child had learnt more at this school than their mainstream school. There was one headteacher, four permanent teachers and sessional teachers that worked when required. When patients were too unwell to attend the education centre off the ward, teachers came to the ward to provide one-on-one support.

Skilled staff to deliver care

- A range of mental health professionals provided input to the wards. Teams were made up of nurses, consultant psychiatrists, speciality doctors, healthcare assistants, family therapists, clinical and assistant psychologists, social workers, dieticians and an art therapist. For the number of beds, the service met the recommended number of staff of different disciplines, as suggested by the Royal College of Psychiatrists' Quality Network for Inpatient CAMHS. A consultant paediatrician also visited the wards on a weekly basis to assess and support specific physical health needs of patents, as well as provide guidance to other staff.
- At the last inspection in March 2016, we found that staff were not regularly accessing individual supervision, which is important for the development of their knowledge and skills to meet the needs of patients. During this inspection, staff said they received individual supervision each month. Records showed an average monthly compliance of 89% across the nurses and healthcare assistants between October 2016 and February 2017. Group supervision and reflective practice was also available to all staff.
- All nursing staff received specialist training for naso gastric feeding. Every fortnight staff could access internal training and academic sessions. These lasted for two hours and covered topics such as autistic spectrum disorder. There were also talks from eating disorders and transgender specialists.

Multi-disciplinary and inter-agency team work

- Staff had multi-disciplinary meetings once a week to discuss the care of each patient. Staff discussed each patient in depth once a fortnight. Staff created an action plan at each meeting relating to care going forwards.
- Between shifts staff attended handover meetings for 30 minutes. In these meetings they shared key updates about individual patients, incidents and risks.
- Staff stayed in touch with teams in other organisations where necessary, such as community mental health teams, and kept records of this. The senior social worker attended the local safeguarding children board meetings and completed the required safeguarding audit for them.

Adherence to the MHA and the MHA Code of Practice

- Nursing and healthcare assistant staff received training in the Mental Health Act (MHA). Compliance was 85% at the time of inspection. Nurses, doctors and MHA administrators received further training in the MHA Code of Practice.
- Staff could explain the process to obtain consent from patients and knew where written information and posters were on the ward about this. Staff said they frequently checked whether the patient continued to give their consent to treatment, where applicable.
- Patients said staff gave them information about their rights when they came to the ward. This included patients who were detained under the MHA and those that were not. Staff said they repeated patients' rights to them monthly.
- In one patient's notes staff had written instructions stating nurses were to apply their holding powers if the

patient attempted to leave the ward. This was not appropriate, as holding powers should be considered and used in response to specific risks at that time, rather than planned.

- Administrative support and legal advice on implementation of the MHA and its code of practice was available from a central team.
- Patients could access Independent Mental Health Advocates (IMHAs). These are advocates who work independently to the service who and are specifically trained within the framework of the MHA. They support patients detained under the MHA to understand their rights and take part in decisions about their care. There were information leaflets about these services in communal areas on the wards.

Good practice in applying the Mental Capacity Act

- Staff received training in the Mental Capacity Act 2005 (MCA). The overall compliance rate was 87%, with 100% of doctors trained. Staff could describe the underlying principles of the MCA, which is applicable to people over 16. Staff explained the principle of assuming patients have capacity to make decisions about their care, unless there is a reason to query this.
- Staff had an understanding of Gillick competence, which is where a person is assessed and deemed to have the competence to make decision about their own care, without the need for parental consent.
- Admission paperwork included staff observations about mental capacity and Gillick competence.
- Information posters about consent and Gillick competence was on display in the clinic room on Lask Ward.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

- We observed caring and supportive attitudes from staff when interacting with patients. At the last inspection, we saw that some staff did not engage patients in conversation. This did not happen during this inspection. Three patients on Nunn Ward said they felt safe, but the wards were noisy and they could hear other patients shouting. They said this could be distressing at times.
- Patients said most staff were kind and caring. They said staff were enthusiastic and engaged well with them. They said staff treated them as individuals and were polite and showed they cared. Most patients said staff knocked on doors before they entered bedrooms, which was positive in terms of respecting their privacy. Feedback from most patients and all parents was that staff understood the individual needs of patients. They said staff focussed on improving quality of life for the individual. One family was able to bring three pets to the service to visit a patient.
- Three out of 13 patients said a small number of staff could be impatient and inconsistent with rules. One patient said staff using the term “temper tantrum” for disruptive behaviour was belittling. Two of four patients on Lask Ward said staff did not always knock before entering.
- Parents gave extremely positive feedback about staff and the care their child received. Parents said staff were dedicated, identified the individual needs of their child, and worked very hard to meet these needs at all times. They said the care their child received was exceptional. One parent said staff always listened to any concerns and made them feel welcomed and involved.
- The service did an annual patient satisfaction survey. Results from the survey in August 2016 showed that of the 21 patients who participated, satisfaction was 61%. This was an increase of 9% from the previous year. The survey covered nine areas, including education, rights, the environment and activities. The best score at 77% was for education. The lowest at 47% was for satisfaction with meals.
- The service asked parents to complete satisfaction surveys. The overall satisfaction rate from August 2016 was 86%. This was completed by 12 parents with children on Nunn Ward and six parents with children on Lask Ward. All eight areas of the survey were scored 81% or over.

The involvement of people in the care they receive

Good

Specialist eating disorder services

- The admissions process informed patients and families about the wards. Patients could tour the service and there was an information pack available for patients and families.
- Patients were involved in giving verbal and written feedback about their care. Staff developed and wrote care plans and then discussed them with patients to gather formal feedback. Five of six records showed there was a lot of feedback from patients recorded in notes. The month before the inspection, the service introduced changes to invite patients to weekly multidisciplinary meetings where they could discuss their care with staff. Although patients were involved in their care in this way, several said they would have liked more involvement in the development of care plans from the start and would like to be able to keep a copy of their care plan. One record showed some inconsistency in the recording of patient involvement. For one patient, the narrative stated the patient did not want to sign or comment on their care plan, but the document was signed with their initials at the end. It was not clear who had written the initials on the document. Staff said that care plans were kept in patient daily folder in the nursing station.
- Patients had access to advocacy services. Advocacy services are independent of the provider and support people to be involved in decisions about their care and access information to explore their choices. Patients on both wards gave positive feedback about the advocate. Two patients on Lask Ward said the advocate could visit that ward more often.
- Staff involved families and carers in care where this was appropriate. Records showed staff carried out parent assessments, collected input for regular care meetings and recorded correspondence in notes. Parents and carers we spoke with said they felt very involved in their child's care. Parents said staff contacted them regularly in a way that suited them and felt able to share information about their child to support treatment. Parents were aware of what care their child was receiving, both for their physical and mental health needs.
- The service ran a monthly parents group for support and psychoeducation. Parents we spoke with who attended this meeting said it was very helpful.
- At the last inspection in March 2016, parents and carers said their experience could be better during visits if the hospital by providing access to hot drinks. During this inspection, parents we spoke with said they could access drinks throughout their visit.
- Patients and families were able to give feedback about the service. Patients attended weekly community meetings where they could give feedback about the service. Three of 13 patients from both wards and the cottages said staff did not always carry out the actions from feedback. Staff said that where suggestions could not be implemented, this was explained to patients. Team meeting minutes showed staff discussed patient feedback regularly as a group. One patient said the community meeting was not a helpful place to give feedback as staff became defensive.

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

(for example, to feedback?)

Good

Access and discharge

- The service accepted referrals from community services and other inpatient services. In January 2017, data showed that 12 of 26 referrals were from other inpatient services. Admissions were planned except in exceptional circumstances, where cases were considered on a case by case basis. Once a referral was made, senior clinical staff attended referral and allocation meetings to decide where the patient would be best placed. The service accepted national and international referrals.
- Bed occupancy between April 2016 and February 2017 ranged from 84% to 98%. The average over this time was 93%.
- The average length of stay for patients who had been discharged in 2016 was around nine months.
- 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.

- Feedback from parents was that staff discussed discharge, but not in detail where discharge was far off. On Lask Ward, one patient's notes stated they would be referred to another service in two months' time, but there was no care plan in place for this. We saw discharge plans in place for patients on Nunn Ward.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms available to support care and treatment, but space on the wards and in the cottages was limited. Each ward had shared bathrooms and bedrooms, a lounge and a dining room. Lask Ward also had an activities room, a female lounge, a quiet room and a treatment room for naso gastric feeding. Corridors were not wide and lounges and dining rooms became crowded if all patients were in them at one time. On Nunn Ward, there was not enough seating for all patients in the lounge. Three patients and two staff members across the two wards said the wards were too small. They gave examples of the impact of this, such as the quiet room on Lask Ward not being quiet, as it was so close to the dining room and corridor. One patient said there was no space to relax. Overall patient satisfaction scores for the environment in a survey from August 2017 were low for the environment, at 49%.
- There was a TV room off the wards that could be booked and was an additional space for patients. There was also a therapy kitchen available off the wards. The dietician and nursing staff ran breakfast club and supported meals with families within this space. This prepared patients and families for discharge. Staff offices were within the main building and also in cabins in the garden.
- Patients shared bedrooms, with most bedrooms accommodating two patients at one time. At the last inspection, we found that dividing curtains to promote privacy and dignity had not been fitted. During this inspection, we saw the service had purchased privacy screens. However, these were not present in bedrooms as patients did not choose to use them. Patients we spoke with during this inspection said they didn't want to use the privacy screens. Most patients said they didn't mind sharing a room, but two of 13 patient said they did not like it. These two patients said there was a lack of privacy, especially as space on the wards was cramped.
- Two patients on Nunn Ward said the showers often flooded the bathroom.
- There was a visitors' room available. Parents said parking could be an issue as there were limited spaces. The service had a welcoming reception area with comfortable seating and information posters. There was a visitors' bathroom and hot and access to hot and cold drinks.
- Patients could access mobile phones and could make calls in private.
- Patients on each ward and the cottages could access the garden. However, this was for a set period of 10 minutes a day and staff accompanied patients. Patients we spoke with said they had enough access to fresh air, as they also went through the garden several times a day to access the school.
- Patients said the food was of good quality during the week, but it wasn't as good on the weekends when there was a different chef. Three patients and one staff member said there could be more variety on offer in the menus. The main chef worked between 7am and 4pm Monday to Friday and offered a menu over four weeks. This menu addressed cultural and religious needs as well as any allergies. The chef attended weekly community meetings to gather feedback from patients.
- Patients were able to personalise their bedrooms. For one patient, staff installed an extra shelf in their bedroom so that they could display personal items. This was done on an individual basis and at the request of the patient.
- Each patient had a safe in their room and could also use a safe in nursing offices.
- There was an activities timetable in place for the weekdays and the service had recently employed two activity coordinators. The weekly timetable included education sessions between Monday and Friday. Patients said there were fewer activities available at the weekends. One patient said staff talked about introducing activities at the weekends, but this had not yet happened. Patients on Lask Ward said there could be more activities available in general.
- One male patient said they would prefer a wider range of sports activities that they enjoyed.

Good

Specialist eating disorder services

Meeting the needs of all people who use the service

- The provider could accommodate one patient with a physical disability and requiring disabled access on Lask Ward. There was a lift available and an en suite accessible toilet and bathroom in one of the bedrooms.
- Information leaflets available in reception and on 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 MHA on site and on the service website.
- 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. There was no information available about age appropriate health promotion, for example about smoking cessation, bullying and 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. There were four case studies from patients who had been discharged and who shared their experience of care and recovery at the service. This was a positive way to engage patients who may be new to the service.
- Food to meet the dietary requirements of religious and ethnic groups was available. However, not all patients we spoke with were aware of this. One patient said this had not been discussed with them and it was something they would like to know about.
- The service could support patients with spiritual or religious needs.

Listening to and learning from concerns and complaints

- Patients and families were aware of how to give feedback about the service, although not all were aware of the formal complaints process. Two of five patients said they felt listened to when they had made a complaint. Three did not feel their feedback was taken on board.
- Staff also collected compliments and shared these at weekly centre operational management meetings. Between October 2016 and January 2017, meeting minutes showed the service received nine compliments. Two of these were about a new weekend receptionist that the service employed following feedback from parents.
- At the last inspection, we found that the service did not always follow their procedures to acknowledge a complaint within seven days. During this inspection, we reviewed complaints received in the 12 months before the inspection and saw this was no longer the case. Since the last inspection, the service had revised its complaints policy. Meeting minutes showed senior staff reviewed complaints regularly and fed back on responses and timeframes for complaints and investigations.
- At the last inspection, we found that the service did not have a feedback box in place to collect feedback forms anonymously. During this inspection, the service had a feedback box at reception. In the 12 months before the inspection the service received 33 feedback forms that it processed as complaints. Feedback forms were available at reception.
- Where an investigation took place related to a complaint, relevant staff received feedback.

Are specialist eating disorder services well-led?

Good

Vision and values

- The organisation's core values and vision were displayed on its website and had been developed since the last inspection. The values were to engage with and treat 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 staff to build a positive environment; to respect the dignity of patients; to work in co-operation with the family of young people by including them in the treatment programme; to work together with honesty and respect and to listen to and act on feedback.

- Staff were aware of the most senior managers in the organisation. Ward staff said the managing director often visited the wards and we saw this take place during the inspection. We saw that patients also knew the managing director and had positive interactions with him.

Good governance

- The service had a clear clinical governance structure and governance processes in place. The service employed a full time clinical governance officer. Since the last inspection in March 2016, the service employed a hospital director who had worked to address concerns highlighted at the last inspection. Several areas had been fully addressed, such as supervision and infection control procedures. The service was also still in the process of embedding other improvements, such as more frequent collection of outcome measures and a new incident reporting system.
- Staff completed an early warning indicator audit to highlight potential risks to the service, including governance processes. This was last completed in February 2017 and covered 16 questions. These included whether there was a ward manager in place for over three months, where nursing vacancy rates and unfilled shifts under 15% and whether supervision and appraisals were completed. The service had a risk register where all risks were highlighted and necessary actions outlined with deadlines.
- Senior management and clinical staff attended regular meetings to discuss the running of the service. This included weekly centre operational management meetings and a monthly quality, safety and standard committee. Staff followed set agendas and covered areas such as incidents, patient feedback and ongoing service development. Staff kept clear and detailed minutes that showed staff completed and regularly fed back on actions.
- There were several non-clinical staff employed to oversee day to day operation of the service. This included receptionists, a Mental Health Act officer, medical secretaries, an HR manager and a ward clerk.

Leadership, morale and staff engagement

- A low number (44%) of staff took part in an annual staff survey in August 2016. Overall satisfaction was 69%. Confidence in the organisation gave the highest score at 79%. Recognition and respect had the lowest score at 63%. A fixed item on the quality, safety and standard committee was staff satisfaction. Minutes from January 2017 showed the service planned to run a workshop to identify desired outcomes and produce action plans.
- The sickness rate in the past 12 months was just under 2% across all staff. The highest rates were for nursing staff at around 3%.
- Staff we spoke with had not experienced and were not aware of any bullying or harassment.
- Staff said they felt able to raise concerns without fear of victimisation. The August 2016 staff survey showed that 78% of staff that took part in the survey said they felt they could report a concern. This was higher than the 2016 benchmark of 70% for all NHS trusts and 72% for mental health and learning disability trusts. One staff member said the organisation could be better at requesting feedback from staff to input into service development.
- The organisation offered several bursaries and placements for staff wishing to access further training.
- Staff were positive about their teams and the support they received from colleagues and managers. Staff on Lask Ward said the acting ward manager was extremely supportive. Staff said there was good communication between the team to share information. Staff said the team were respectful of one another's contributions.
- Staff on Lask Ward said they could get more support from more senior managers, who may not have a full understanding of their experience of working on the ward. They said their work could be better acknowledged, as the work on Nunn Ward was.
- Staff were open and transparent and explained to patients and families if something went wrong.

Commitment to quality improvement and innovation

- The service participated in the national quality improvement programme for CAMHS, run by the Royal College of Psychiatrists. This involved annual peer reviews.
- Staff at the service participated in several pieces of external research. The service was involved in the development of a new Headspace Toolkit. This is an

information pack available nationally for inpatients about their rights whilst on a ward and helpful information about inpatient treatment. The service was the project lead for developing young person specific national guidance for the prevention management of violence and aggression, which is currently only available for adults. The service was involved in the design of a new chair that can be used by patients requiring naso gastric feeding. Parents we spoke with said staff shared pictures and information about this chair with them as the project developed. The service had also fed into a national service specification document for inpatient CAMHS services.

- One of the consultant psychiatrists was the psychiatric representative on the British Psychological Society's eating disorder reference group, and was also involved in the production of National Institute for Health and Care Excellence(NICE) guidelines. Another Consultant was on the Management of Really Sick Patients under 18 with Anorexia Nervosa (Junior MARSIPAN) steering group.
- The service were also carrying out several internal projects. This included the internally developed tool called the patient inclusion in least restrictive intervention management plan (PILRIMP) and a strategy to reduce restrictive practice.

Outstanding practice and areas for improvement

Outstanding practice

- The service was involved in the update of a national information source for people under 18 in inpatient care, called Headspace Toolkit.
- The service was the project lead for developing national guidance for the prevention management of violence and aggression specifically for people under 18. It is currently only available for adults.
- The service was involved in the re-design a chair that can be used by patients requiring naso gastric feeding.
- The service used a tool they had developed internally which aimed to reduce restrictive interventions, including the use of physical restraint during naso gastric feeding. It was called the patient inclusion in least restrictive intervention management plan (PILRIMP). Staff developed plans collaboratively with the patient and their parents/ carers where appropriate.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure quality of food remains the same over the weekend.
- 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.