Riverdale Grange Clinic

Quality Report

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Date of inspection visit: 14 and 15 August 2018
Date of publication: 16/10/2018

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Riverdale Grange Clinic as good because:

- Patients had access to a wide range of therapies and professionals within an effective multi-disciplinary team. Patients and carers told us that therapy was personalised and specific to individual need. Families and carers were encouraged to be actively involved in patient care, and were offered support and education programmes.
- Staff morale was high and staff told us they felt well supported and valued in their roles. Staff supervision and appraisal rates were above 80% across both units.
- Patients had access to a timetable of activities on both units and were encouraged to complete individual weekly planners detailing activities they intended to attend. Patients were also involved in a social enterprise which encouraged them to try new activities whilst raising awareness of eating disorders in the local community.
- Robust physical health monitoring was in place throughout patients' admission, overseen by two general practitioners. There was an on-call rota for managers and consultant psychiatrists for support and advice out of hours in order to maintain the safety of staff and patients.
- Adolescent patients could access an on-site education provision during term-time, with school staff maintaining contact with the patient's education provider outside the hospital.
- Staff at the hospital were involved in peer review of other eating disorder services; allowing them to share knowledge and engage in learning opportunities.

However:

- Staff did not consistently complete patient medication cards following the administration of medication. Fridge temperatures in the adolescent clinic room regularly exceeded the recommended range. It was not clear that emergency medication, namely EpiPen's, were stored in line with manufacturer's guidance, and one of the emergency bags did not contain the correct equipment identified on the equipment check-list.
- Mandatory training compliance for eating disorders awareness and therapeutic observation training modules was low. This meant that staff may not have been aware of the specific risks and complications associated with eating disorders in order for them to safely care for patients.
- Adolescent patients had not been individually risk assessed to establish whether they required supervision whilst accessing the hospital garden. Patients' rights under the Mental Health Act were not clearly displayed on the adolescent unit.
- Staff could not identify where consent to share information was stored within patient notes and we could not see evidence of a clearly documented assessment of capacity for a patient who had been deemed not to have the capacity to make a specific decision.
- Governance structures in place at the hospital did not effectively manage all of the concerns identified.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Good

Riverdale Grange Clinic

Services we looked at:
Specialist eating disorders services;

Summary of this inspection

Background to Riverdale Grange Clinic

Riverdale Grange Clinic is an independent hospital providing treatment and care to people with an eating disorder. It is located in an extensively refurbished Edwardian building with landscaped gardens, not far from the centre of Sheffield. The hospital has 18 in-patient beds in two separate units; one treating up to nine adult patients and the other treating up to nine young people. The hospital provides treatment mostly for female patients, however, there is appropriate space available to treat one male patient. At the time of our inspection, all the patients in the hospital were female.

The hospital currently has two registered managers, one primarily for the adult unit and one for the adolescent unit. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Registered managers have a legal responsibility for meeting the requirements of the Health and Social Care Act, 2008 and associated Regulations about the running of the service. The registered manager for the adult unit also acts as the hospital's accountable officer for controlled drugs. Riverdale Grange Clinic has been registered with the CQC since 19 January 2011. It is registered to carry out three regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act, 1983, (child and adolescent unit only)
- diagnostic and screening procedures
- treatment of disease, disorder or injury

There has been a total of six inspections carried out at Riverdale Grange. The last one was a focussed follow-up inspection in August 2017. At that inspection, we identified the following breaches of the regulations:

- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

We told the provider they must take the following action:

- The provider must ensure they monitor compliance with staff mandatory and essential training.
- The provider must ensure that staff take sufficient steps to inform patients receiving naso-gastric treatment of their rights regarding mental health advocacy in treatment reviews.
- The provider must ensure all staff receive training in the Mental Capacity Act, 2005.

In addition, we told the provider they should take the following actions:

- The provider should ensure procedures for fit and proper persons checks are clearly documented in the relevant policy.
- The provider should ensure there is a robust procedure for ensuring policies are reviewed in line with stated review dates.

Following inspection the provider created action plans relevant to the above requirements and suggestions which were reviewed through engagement and during the current inspection it was found that these actions had been completed.

Our inspection team

The team that inspected the service comprised two CQC inspectors including the team leader, and three specialist advisors; one mental health nurse, one psychologist and one occupational therapist.

Summary of this inspection

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, met with members of the management team as part of our ongoing engagement with the provider, and we asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited both units at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 5 patients who were using the service
- spoke with 6 carers of patients who were using the service
- spoke with the director of clinical services, who was also the registered manager and service manager of the adult unit. We also spoke with the service manager of the adolescent unit, and the director of non-clinical services
- spoke with the two ward managers
- spoke with 22 other staff members; including doctors, nurses, dieticians, occupational therapists, psychologists and support workers
- spoke with an independent advocate
- attended and observed a hand-over meeting and a ward round
- collected feedback from 12 patients using comment cards
- looked at seven treatment records of patients
- carried out a specific check of the medication management on both units
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

During inspection we spoke with five people who used the service. Following inspection, we spoke with six carers by telephone and received feedback from 12 patients using comment cards.

Feedback from patients and carers was mainly positive with regards to staff, treatment and the environment. Patients told us staff were supportive, patient and caring. Patients and carers told us that they felt treatment was personalised and individually tailored to meet patient's needs. Patients and carers also told us that treatment was holistic and that staff worked with patients to understand and treat the underlying causes of their eating disorder. Patients told us they found the environment comfortable and homely.

Carers told us they felt involved in patient care and were supported by staff to maintain their own wellbeing through access to carers' groups.

Both patients and carers told us that they felt able to give feedback and raise complaints where necessary.

However, one patient spoken with told us that they did not have an up to date care plan and another told us that they had asked for a copy of their care plan a number of times before it was provided. Two patients also told us that they did not feel that staff listened to them when deciding on their care and treatment.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Staff did not consistently complete patient medication cards following the administration of medication.
- Mandatory training compliance for eating disorders awareness and therapeutic observation training modules was low. Due to the specialist nature of the service there was a concern that without having undertaken eating disorder awareness training staff may not be aware of the specific risks and complications associated with eating disorders in order for them to safely care for patients.
- Adolescent patients had not been individually risk assessed to establish whether they required supervision whilst accessing the hospital garden.
- Fridge temperatures in the adolescent clinic room regularly exceeded the recommended range.
- Emergency medication, namely EpiPen's, were not stored in line with manufacturer's guidance, and not all equipment listed as contained within one of the emergency bags was present.
- Patients' rights under the Mental Health Act were not clearly displayed on the adolescent unit.

However:

- Both units, including clinic rooms, were clean and well-maintained.
- The hospital ran an on-call rota for consultant psychiatrists and ward and senior managers to ensure staff on the units had support out of hours.
- Staff were trained in safeguarding and had a good understanding of how to report safeguarding concerns and incidents.
- We observed staff to respond promptly and safely to a patient alarm activated during our inspection and found that nurse call alarms were located in all rooms within the hospital.

Are services effective?

Good

We rated effective as good because:

- Physical health monitoring was in place with patients receiving a physical examination on admission and an appointment with a general practitioner within four hours, as well as ongoing monitoring throughout admission.

Summary of this inspection

- Patients had access to a wide range of professionals within an effective multi-disciplinary team.
- Patients had access to a range of therapies recommended by the National Institute for Health and Care Excellence (NICE).
- Patients saw a dietician within 12 hours of admission. Dieticians worked with patients to create personalised meal plans which would be reviewed regularly at ward rounds.
- The hospital used recognised rating scales to assess and record severity and outcomes.
- Staff supervision rates were above 90% and staff appraisal rates were above 80% across both units.

However:

- Staff did not follow the Mental Capacity Act code of practice process when assessing for and documenting capacity. Some staff lacked understanding of the Mental Capacity Act.
- Staff printed and stored patient care plans within a paper-based folder on the adult unit for bank and agency staff to refer to for information about patient care, but many plans were not up-to-date a number were missing entirely.
- Staff could not always identify where consent to share information was stored within patient notes.

Are services caring?

Good

We rated caring as good because:

- We observed positive interactions between staff and patients and saw staff to be respectful and supportive. Patients and carers were largely positive about staff.
- Families and carers were invited to attend a carer's group aimed at providing education around eating disorders as well as peer support.
- Prior to admission patients received a handbook detailing what they should expect during their stay, therapies and activities available, details of staff at the hospital and information on advocacy and complaints. Patients were also invited to tour the hospital prior to admission.
- Patients and carers were actively involved in regular ward round and care programme approach meetings.
- Patients were involved in creating an interview pack for prospective employees, with questions based on domains they felt were important.

However:

- One patient spoken with told us that they had asked for a copy of their care plan a number of times before it was provided.

Summary of this inspection

- Two patients told us that they did not feel that staff listened to them when deciding on their care and treatment.

Are services responsive?

Good

We rated responsive as good because:

- Patients and carers told us they knew how to complain and would feel comfortable doing so if required.
- Patients had access to a timetable of activities on both units and were encouraged to complete individual weekly planners detailing activities they intended to attend.
- There was disabled access to the hospital and lifts were available to access other floors within the building.
- There was on-site education provision available to adolescent patients during term-time. School staff maintained contact with patient's education provider outside the hospital to ensure work was of an appropriate nature, as well as to support transition once discharged.

However:

- Activities were not scheduled on weekends and two patients from the adult unit told us that they felt there were not enough activities available off the unit.

Are services well-led?

Good

We rated well-led as good because:

- Staff told us that senior managers were visible on both units and that they could approach them for support.
- Staff morale was high and staff told us they felt valued.
- Staff and patients were engaged in a number of projects aimed at improving quality and raising awareness of eating disorders in the local community, including a social enterprise called 'by Riverdale' which encouraged patients to engage in a range of activities.
- Staff at the hospital were involved in peer review of other eating disorder services through accreditation with the Royal College of Psychiatrists Quality Network for Eating Disorders (QED).

However:

- Governance structures in place at the hospital were not effective in managing all the concerns identified in relation to medication management and staff training.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff we spoke with had a good knowledge of the Mental Health Act including the guiding principles. Compliance with Mental Health Act training was 86% across both units.

Detention paperwork was correctly completed, was up to date, and was stored securely. The hospital had a Mental Health Act administrator who offered support to staff to make sure the act was correctly followed in relation to renewals, consent to treatment and appeals against detention.

The inspection team saw documentation of consent to treatment forms within patient's electronic files. These were not attached to medication charts but staff told us they knew how to find the forms when required. When we asked staff where they would record whether a patient had consented to share information with others they told us this would be recorded within patient progress notes on the electronic database. However, staff were unable to find this when asked to do so by members of the inspection team.

The hospital did not carry out audits to ensure correct application of the Mental Health Act but were in the process of developing an audit tool for monitoring adherence with consent to treatment documentation.

Mental Capacity Act and Deprivation of Liberty Safeguards

Compliance with Mental Capacity Act training was 87% across both units. However, not all staff spoken with had a good understanding of the Mental Capacity Act, for example a member of staff on the adolescent unit did not have knowledge of Gillick competence.

The hospital had a Mental Capacity Act policy which was last reviewed in July 2018. The policy made clear the five main principles of the act and referred to Deprivation of Liberty Safeguards. It also referred to Gillick competence and Fraser Guidelines; used for assessing whether a child under 16 years of age can give valid consent.

Staff spoken with were clear that patients were assumed to have capacity to make their own decisions. Staff told us that if they had concerns about a patient's capacity to make a particular decision then they would speak with one of the consultant psychiatrists. However, the hospital's Mental Capacity Act policy did not provide details of a named persons or persons whom staff should go to for support and advice.

We saw evidence of staff discussing capacity with regards to a patient, but we did not see a clearly documented assessment of the patient's capacity, nor of any discussion around best interests and what this would look like for the patient.

There were no patients cared for under Deprivation of Liberty Safeguards at the time of inspection.

The hospital did not conduct audits of adherence to the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Good

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

All areas of the hospital were clean and well maintained and furnishings were of good quality.

There were several environmental risk assessments in place to cover all areas of the hospital. These were last updated in May 2018 and considered existing risk control measures as well as any action plans required as a result of risks identified. There was also an up to date fire safety risk assessment completed 25 August 2017 and the hospital had been audited by the local fire and rescue authority on 19 September 2017. Relevant staff members had completed actions required as a result of this audit. During inspection the inspection team raised a concern with the management team regarding a number of fire doors within the building that did not automatically open in the event of a fire alarm being activated, and which could only be opened by a fob held by staff. These doors were located on the adolescent unit entrances and exits. Once alerted to these concerns staff conducted checks and liaised with the hospital's fire officer to ensure all fire doors would automatically open in the event of a fire alarm being activated. The service director assured the inspection team that the hospital's fire safety risk assessment would be reviewed and updated to reflect these risks and actions taken to reduce risk.

The layout of both units meant that staff did not have a clear line of sight to allow them to observe all parts of the units. This was mitigated through the use of mirrors placed within various areas of the units, and through individualised observation levels.

Both units had an up to date ligature risk assessment in place completed on 06 July 2018 on the adult unit and 19 June 2018 on the adolescent unit. A ligature point is anything that could be used to attach a cord, rope or other material, for the purpose of hanging or strangulation. These risk assessments identified a number of ligature points throughout the hospital as well as mitigation for these risks, including through individualised observation levels. Where specific risks had been identified that could be reduced or removed we saw staff had created an action plan with timescales for any work to be carried out.

The adolescent unit had the facility to appropriately accommodate one male patient at a time. There were no male patients on the unit at the time of inspection.

The hospital did not have a seclusion room.

Both units had a fully equipped clinic room which staff checked regularly. Staff had access to physical health equipment including blood pressure and blood glucose monitors, weighing scales and electrocardiogram machines, which were clean and in working order. Resuscitation equipment was in two emergency bags, of which one was stored in the reception area of the hospital and one in the nurses' office on the adolescent unit. The emergency bags were checked daily by staff against a list of standard contents. Whilst there was evidence of staff signing to say the contents of the emergency bags were checked, the inspection team found that in the bag on the adolescent unit only six razors were present when the list

stated there should be nine. This did not appear to have been noted by staff and as such it was not clear when the number of razors had changed or if they were missing. There could be risks to patients if sharp implements were unaccounted for by staff.

Staff adhered to infection control principles. Staff and patients had access to hand wash and hand sanitiser on the units and staff received training in infection prevention. Equipment was clean and well maintained.

Nurse call alarms were located in all rooms within the hospital. Panels were located in key areas of the hospital to indicate to staff the location of an activated alarm. We observed staff to respond promptly and safely to an alarm activated during our inspection.

Safe staffing

The total number of qualified nurses and support workers was 39 whole time equivalent staff across both units. There was 7.8 whole time equivalent qualified nursing vacancies and no support worker vacancies across both units. Safe staffing levels were maintained through the use of a professional judgement staffing tool and staffing records reviewed between 9 July 2018 and 12 August 2018 showed at least one qualified nurse was present on each unit at all times. Senior managers told us that eight qualified nurses had recently accepted roles at the hospital and were due to start work at the hospital in the next two months, which would bring the hospital up to establishment levels for qualified nurses.

At the time of inspection bank and agency staff were being used to fill shifts not covered by permanent staff. Between 01 January 2018 and 31 March 2018 118 shifts were covered by bank staff on the adolescent unit, and 42 on the adult unit. During the same time period 33 shifts were covered by agency staff on the adolescent unit and 72 on the adult unit. A total of 44 shifts across the two units were not covered by bank or agency staff. Senior managers told us they ran an internal bank system which utilised staff who knew patients and had the same induction as permanent members of staff, and that when agency staff were used they were consistent members of staff who were familiar with the hospital and patients. Senior managers also told us that when agency and bank staff were not available to cover shifts ward managers or on-call managers would provide support, or staff would be moved between the two units, to ensure safe staffing levels. Ward managers told us that they could adjust staffing levels daily when required due to patient acuity.

Patients and staff told us that there were enough staff available for patients to have regular 1:1 time with their named nurse or support worker, and that escorted leave and unit activities were rarely cancelled due to staffing levels.

The hospital employed two consultant psychiatrists to provide on-call cover, with one consultant being on-call at all times. Consultants confirmed they could attend the hospital quickly in an emergency and were contacted regularly by staff for advice. Staff told us they could also contact one of the GPs who worked at the hospital who lived locally and would attend the hospital in an emergency if required.

Compliance rates for mandatory training were provided prior to inspection. The provider gave details of 21 mandatory training modules. Staff compliance was above 75% for 16 of these modules. However, the following mandatory training modules were noted to be below 75% compliance;

- Hospital life support: 62.1%
- Team skills restraint (adult unit): 73.7%
- Nasogastric tube feeding (adolescent unit): 63.2%
- Eating disorder awareness: 57.9% (adolescent unit) and 63.2% (adult unit)
- Therapeutic observation (adult unit): 10.5%

During inspection we reviewed training data which showed that compliance in team skills restraint training had increased to 80.77%, but compliance for all other mandatory training modules identified above remained below 75%. Information showed that for hospitals life support and nasogastric tube feeding enough staff were booked on to upcoming courses to bring compliance above 75%. However, for eating disorder awareness and therapeutic observation training modules, compliance remained low. For therapeutic observation, 22 staff members who required the training were not in date, and only five of these 22 staff members were booked onto an upcoming course. For eating disorder awareness, 21 staff members who required the training were not in date, and again only five of these 21 staff members were booked onto an upcoming course. Senior managers told us that

therapeutic observation was only recently made a mandatory module. Staff told us that it could be difficult to access training if they worked part-time and courses only ran on certain days of the week. However, due to the specialist nature of the service it is possible that without having undertaken eating disorder awareness training staff may not be aware of the specific risks and complications associated with eating disorders in order for them to safely care for patients.

Assessing and managing risk to patients and staff

During inspection we reviewed seven care records. Staff used the designated risk assessment on the hospitals electronic system. Only one of the care records did not contain an up-to-date risk assessment. We saw evidence that risk assessments were reviewed monthly at patient care programme approach meetings. Minutes from these meetings clearly showed risk being discussed.

There were some restrictions in place at the hospital. Access to the garden area for adolescent patients was only allowed under the supervision of staff. Senior managers told us that they had a duty of care to the patients due to their age range. However, we could not see evidence that staff assessed risk with regards to utilisation of outdoor space on an individual basis.

Mobile phones were permitted for use within the hospital, but there were restrictions around time of use on both units, for example mobile phones were not to be used at the dining table on either unit, and on the adolescent unit mobile phones had to be handed in to staff and patients could only use them during allocated 'phone time'. These restrictions were clearly detailed within the patient welcome packs and handbooks, and patients were asked to agree to these conditions as a prerequisite of their admission. Restrictions were also clearly detailed and rationales given within the hospital's 'use of mobile phones' policy.

Kitchen areas were locked, with fob access, and could only be used by patients under supervision of staff. Senior managers told us that kitchen use was supervised to allow staff to monitor fluid and dietary intake as part of a patient's treatment, and to enable staff to manage risk around sharp items and ligature points. Patients were allowed to access kitchens under supervision to help clear away after meals, and as part of their progressing treatment to encourage patients to begin to self-cater. We also saw evidence that patient risk regarding self-harming behaviours was discussed and documented on an individual basis through care programme approach meetings.

There was no unrestricted access to food and drink outside mealtimes due to the nature of the service, in order for staff to monitor patients' fluid and dietary intake as part of their treatment plan. However, patients and staff told us that patients could ask staff for a drink outside designated times and that this would be provided unless there was a health concern, for example, about the amount of water a patient was consuming.

Informal patients could leave at will from the adult unit and details explaining 'your rights as an informal patient' were displayed in patient areas. However, on the adolescent unit we did not see evidence of information displayed explaining informal patients' rights. However, the informal patients we spoke with on inspection told us they knew they were free to leave at any time.

There were policies and procedures in place for use of observation. All patients were subject to a minimum of hourly observations for the duration of their treatment and this was made clear within the handbook given to patients on admission. Observation levels could be increased as and when required to minimise risk. We saw that observation records were completed appropriately. Staff told us that they would only search patient's belongings if patients gave their permission and staff had reason to believe the patient might be trying to bring something into the hospital that could pose a risk to someone. If patients did not give permission, staff would not search the patient but would increase observation levels to minimise risk.

The hospital provided data relating to the use of restraint between 1 October 2017 and 31 March 2018. Data showed three incidents of restraint involving two patients on the adolescent unit, and no incidents of restraint on the adult unit. Staff on both units told us that restraint would only be used as a last resort and that de-escalation techniques such as talking with and distracting patients would be used in the first instance. The hospital did not have a seclusion room and therefore there were no incidents of seclusion recorded. The hospital did not record any incidences of the use of rapid tranquilisation and staff told us this was not

used at the hospital. Managers told us they planned to include a statement in their revised medication management policy to explicitly state that rapid tranquilisation was not used at the hospital.

Staff were trained in safeguarding both adults and children and compliance with training was above 90% for both courses. Whilst no safeguarding alerts were made to CQC between 30/06/2017 and 30/06/2018, staff could describe different types of abuse and had a good understanding of when a safeguarding alert should be made. The hospital incident reporting system contained a link by which to make a safeguarding referral and staff described positive relationships with the local authority. Staff could give examples of where they had cared for a patient subject to a child in need plan and had subsequently attended relevant safeguarding meetings with the local authority.

The management of medicines at the hospital was reviewed by an externally contracted pharmacist who carried out audits every six weeks. Qualified nursing staff at the hospital also carried out weekly internal clinic room audits. However, a number of concerns regarding medicines management practice were found by the inspection team.

We reviewed medicines charts for 15 patients admitted at the time of inspection. Of these 15 patients we identified inaccurate record keeping for eight patients, with a total of 13 occasions between 10 July 2018 and 14 August 2018 where staff had not signed patient medication records This meant it was not clear whether the patient had taken their medication or not. Senior managers told us that they were aware of this issue and that ward managers had raised this within nurses' meetings to try and address the issue. We reviewed minutes from nurses' meetings and saw that on 31 May 2018 checking for gaps in medication cards was added to the internal clinical audit following gaps being found. Despite this check being added to the weekly audit we saw minutes from a nurses' meetings on 5 July 2018 and on 8 August 2018 stating that missing signatures were still evident. We reviewed internal clinic room audits for both units between 4 May 2018 and 8 August 2018 and found that on 15 audits out of 18 reviewed staff had identified missing signatures on patient medication charts but they did not identify how many gaps they had found. We then reviewed external pharmacy audits carried out in May, June and August 2018. In May 2018 it was identified that there were five gaps affecting three patients on the adolescent unit, and gaps for all eight patients on the adult unit although it was unclear how many as it stated 'several' or 'lots' for each patient. In June 2018 it was identified that there were 11 gaps affecting six patients on the adolescent unit, and nine gaps affecting five patients on the adult unit. In August 2018 it was identified that there were 11 gaps affecting five patients on the adolescent unit and 14 gaps affecting four patients on the adult unit. Whilst we saw that managers had put action plans in place to address these errors, we could not see that the problem had been rectified fully. Staff continued to make errors which carried a risk of patients being administered too much medication.

The hospital had one fridge for medications which was in the clinic room on the adolescent unit. Staff checked fridge temperatures daily. However, when we reviewed temperature charts we saw that staff had noted on 25 occasions in previous last three months that temperatures were above the recommended range of between two and eight degrees centigrade. On 20 June 2018, senior managers identified that the fridge might be faulty but they had not ensured the fault had been rectified by the time we carried out our inspection in August 2018. We raised this at our inspection and following that, managers informed us that an approved engineer visit had been arranged and that the fridge had been repaired.

During inspection it was identified that the hospital had four EpiPen's (a medical device for injecting a measured dose of adrenaline). At the time of the inspection, the EpiPen's were stored in emergency bags; one of which was in the hospital's reception area where temperature was not monitored. The packaging of the EpiPen's stated that the medication should be stored below 25 degrees centigrade to ensure effectiveness. Following inspection the service manager assured us that EpiPen's were relocated to an area where the temperature was monitored to ensure storage in line with manufacturer's instructions.

Clinic room temperatures were measured to ensure temperatures did not exceed 25 degrees centigrade. We saw the room temperature chart for the adolescent unit from August 2018 and could see that on two occasions the room temperature exceeded this temperate. Instructions on the chart stated that if temperature exceeded 25 degrees centigrade then this should be highlighted in the comments section and reported to the ward manager. We could not see evidence that on the two occasions identified that these instructions were followed. Staff used different

systems for recording temperature with some writing the full date and others using the numbers pre-populated on the relevant chart. Senior managers acknowledged that this could be confusing and told the inspection team that the form would be reviewed to make the date clearer.

Families and carers, including children, were encouraged to visit the hospital. There was space available on both units with children's toys and games, and staff told us that visitors could use the garden rooms for privacy when visiting.

Track record on safety

No serious incidents occurred in the 12 months prior to inspection. The provider was aware of the requirement to notify NHS England and CQC within two working days of any incident being identified.

Reporting incidents and learning from when things go wrong

Staff told us that they reported incidents via an electronic incident reporting system. All staff spoken with knew how to report incidents and what they should report. All incidents were automatically sent to, and reviewed by, a relevant manager.

Staff could give examples of incidents they had reported, and changes that had been made as a result. For example, a staff member told us they had reported an incident of a visitor falling in reception and as a result hazard tape and a sign were put in place.

Managers discussed incidents quarterly at senior management team meetings. They identified any themes within incidents reported and also identified any areas for change or improvement to practice as well as areas where lessons could be learned. Staff told us that any changes in practice or lessons learned would be discussed at weekly team meetings, or if urgent at daily handover meetings. Staff told us they would also be communicated via email to ensure all staff were aware. Staff also told us that they had the opportunity to attend case presentation sessions with an external professional whereby they could present and discuss difficult cases in order to learn from one another.

Staff could describe the principles of being open and transparent, and the need to explain to patients when things went wrong, but did not always recognise this as the duty of candour. Duty of candour training was mandatory for staff, with compliance being reported as 88.4%.

Staff told us that they would receive a debrief following a serious incident. Staff stated that this would be done as a team, or individually, depending on the nature of the incident and the preferences of staff. Whilst the hospital had not experienced any serious incidents in the 12 months prior to inspection staff told us that they had found out that a former patient had died and as a result hospital managers had set up a debrief with staff to ensure they were supported.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

During inspection the inspection team reviewed seven care records. Patients received a comprehensive assessment prior to admission and staff created an initial care plan, known as a '72 hour care plan' on the day of admission.

All care records reviewed showed that a physical examination was undertaken on admission. Newly admitted patients were seen by a GP within four hours of their arrival at the hospital. Staff utilised the National Early Warning Scores measure to detect and respond to any clinical deterioration in patient health. Measures were initially completed every four hours for the first three days of a patients stay due to the risks associated with refeeding syndrome (when patients who have been on a severely restricted diet begin to eat again), including biochemical, cardiovascular and fluid balance disturbances. After this time staff monitored patients according to individual need. Ongoing physical health monitoring was evident with patient reviews taking place monthly with a GP as well as necessary checks being undertaken by qualified nursing staff. Patients at risk of pressure sores were monitored using Waterlow scoring, and staff told us they would refer patients to the local hospital for bone density scans where necessary.

When we asked to see documentation of care planning staff presented us with two separate documents. We saw evidence that within 'co-produced recovery outcomes focused care programme approach progress plans' it was evident that staff discussed with patients their progress,

physical and psychological health, life skills, risk assessment, and recommendations and plans for discharge. These notes were holistic and personalised, with patients and their families involved in discussions around family holidays, interests, goals for future work and study, and financial and social considerations and concerns. These progress plans were completed with patients monthly at care programme approach meetings, and patients could invite relevant professionals including external school teachers, and mental health professionals, to support them and provide input to patient's ongoing care plans. However, we were also shown 'care plans' which focused mainly on physical health, mental health and nutrition. The patient-voice was not always evident, and care plans appeared to be task-focused with lists of goals or tasks to be done, such as reaching a certain weight, or only engaging in a certain amount of exercise. Care records as a whole did contain the information required, and patients and carers spoken with told us they knew about their treatment plan and were happy with the care they were receiving.

Information relevant to patient care was stored online on the hospital's records system. Staff told us they knew how to access information and could find it when needed. Senior managers told us that bank and agency staff could access patient information they would require via this system to enable them to read and make entries on progress notes. Staff told us that patient care plans were printed and stored in a paper folder to allow staff to access them quickly; particularly agency staff who may not know patients as well. However, when we reviewed this folder we found that on the adult unit only five out of nine patient care plans were contained within, and of the five contained, two were not the most up to date care plans for the patients. Furthermore, patient progress plans were not contained, which as noted above contained more personalised information relevant to patient care. This means that agency staff may not be adequately informed about patients and their care.

Best practice in treatment and care

Patients had access to psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE) including cognitive behaviour therapy and family therapy. Patients also had access to occupational therapy and other complementary therapies including aromatherapy. Therapies were delivered in a group setting or on a one-to-one basis and patients created personalised activity timetables so that they were aware of when their sessions were taking place.

There was a clear pathway for psychological therapies starting with an initial assessment for therapies within a week of admission. A treatment phase then followed this whereby patients would receive therapy based on their individual needs.

In line with National Institute for Health and Care Excellence guidance, medication was not offered as the sole treatment for any eating disorder and was only prescribed where necessary to support with improvements in physical and/or mental health. When nasogastric feeding was required on the adolescent unit, the hospital's policy was adhered to, written in line with National Patient Safety Agency (NPSA) guidance on safe insertion and feeding. Only staff who had completed up-to-date nasogastric feeding training and had been signed off as competent by their supervisor were allowed to carry out any nasogastric responsibilities with patients.

Patients physical health was monitored by qualified nursing staff on a regular basis specific to individual patient need, and was reviewed by a GP on a minimum of a monthly basis. Patients saw a consultant psychiatrist weekly as a minimum during ward round, but could see them more regularly if required. Senior managers told us that access to specialists in many areas of physical health including skin viability and physiotherapy would be arranged if required.

A dietician assessed patients' nutrition and hydration needs within 12 hours of their admission and identified a personalised meal plan based on the individual's needs and current physical presentation. The hospital had written guidance on how to manage risks of refeeding when prescribing a diet plan. Meal plans would be regularly reviewed and a copy placed in patient notes as well as being displayed on a board within the staff office to ensure staff were aware of individual advised nutrition and dietary intake. Staff told us that food and drink were not made readily available to patients outside of meal and snack times due to the risk of patients drinking excessive amounts of water in order to alter weight readings. However, patients told us that they could request food and drink outside of these times and staff would provide it for them unless it was not safe to do so.

Staff used recognised rating scales to assess and record severity and outcomes, including the Health of the Nation Outcome Scale (HoNos) to measure a wide range of health and social domains, the Eating Disorder Examination Questionnaire (EDEQ) to measure the range and severity of eating disorder symptoms, and National Early Warning Scores (NEWS) to measure any physical health deterioration. Staff told us that depending on the individual needs of the patient they may carry out additional measures including the Beck Youth Inventory, to monitor symptoms of depression, anger, anxiety, and disruptive behaviour, and Waterlow scoring to measure the risk of pressure sore development.

The hospital had an audit schedule detailing audits due to be carried out monthly, six-weekly, quarterly, six-monthly, or annually. A number of audits were currently under development and so auditing had not yet started in areas including care planning and consent to treatment documentation. We saw evidence of a nasogastric tube use audit which demonstrated review of use between 1 September 2017 and 30 November 2017. A relevant action plan had been completed.

Skilled staff to deliver care

There was a full range of mental health disciplines providing input to the hospital, including consultant psychiatrists, qualified nurses, support workers, occupational therapists, GPs, psychotherapists, psychologists, and complementary therapists. Each unit had a designated dietician who worked with patients to create and progress personalised meal plans throughout a patient's treatment.

Staff told us that they received an appropriate induction upon joining the service, including being given an induction booklet, being orientated to the building, and shadowing other members of staff. Senior managers told us that agency and bank staff would also receive an induction before their first shift at the hospital.

Figures provided by the hospital prior to inspection showed that staff supervision rates were 92% on the adolescent unit and 95% on the adult unit, and staff appraisal rates were 83% on the adolescent unit but only 60% on the adult unit. During inspection the service director told us that appraisal rates for staff on the adult unit had improved since data was requested. Documentation provided showed that at the time of inspection 47 out of 56 staff requiring an appraisal had received one in the last year, meaning that overall appraisal rates had increased to 84%.

Staff had access to weekly team meetings and those that were unable to attend received copies of minutes by email. During inspection, we saw a staff member reading team meeting minutes on their return from a period of absence.

Staff discussed any training needs with their relevant managers who supported them to access external training opportunities. For example, qualified nurses at the hospital had recently completed a six-week solution focused therapy course, and a member of administrative staff had received additional training in reception skills and minute taking. Staff members had also been approved to undertake additional training in areas including managing self-harm and difficult conversations.

Poor staff performance was addressed promptly and effectively. In the 12 months prior to inspection three members of staff were placed on paid leave whilst appropriate disciplinary processes were undertaken. All cases were dealt with via appropriate disciplinary processes.

Multi-disciplinary and inter-agency team work

Members of the multi-disciplinary team, including dieticians, GPs, consultant psychiatrists, lead nurses and hospital managers, met once a month for a professionals meeting to discuss policy and procedure and to ensure staff were working cohesively to provide good patient care.

Staff reviewed all patients in a weekly ward round which was attended by relevant members of the multidisciplinary team. Nursing staff and support workers attended handovers which took place daily in between shifts allowing them to share pertinent information about patients including mood, activity, dietary intake and physical health.

Senior managers told us that there were good working relationships with the local NHS psychiatric and acute facilities, as well as with patient's care co-ordinators in the community, and with staff at adolescent patient's school facilities. We saw evidence within a patient's progress notes

of discussions with a community care co-ordinator to discuss the patient's discharge. Staff invited relevant professionals to attend monthly care programme approach review meetings.

Adherence to the MHA and the MHA Code of Practice

Staff we spoke with had a good knowledge of the Mental Health Act including the guiding principles. Compliance with Mental Health Act training was 86% across both units. Whilst staff on the adult unit did not work with detained patients there was on occasion a requirement for staff from the adult unit to support on the adolescent unit where they may be required to support and care for detained patients.

The hospital had a Mental Health Act administrator who offered support to staff to make sure the act was correctly followed in relation to renewals, consent to treatment and appeals against detention. Most staff spoken with knew who their administrator was and those that didn't stated that they could access support from either of the consultant psychiatrists at the hospital.

At the time of inspection, the hospital was caring for two adolescent patients detained under the Mental Health Act. Detention paperwork was correctly completed, was up to date, and was stored in a separate folder in the staff office. Both patients had been recently detained and did not yet have leave in place. Staff confirmed that any record of leave would be recorded, with the original authorisation in the patient's Mental Health Act detention papers, and a copy stored in a file on the unit so that staff were clear on what leave a patient had.

The inspection team saw documentation of consent to treatment forms within patient's electronic files. These were not attached to medication charts but staff told us they knew how to find the forms when required. When we asked staff where they would record whether a patient had consented to share information with others they told us this would be recorded within patient progress notes on the electronic database. However, staff were not always able to find this when asked to do so by members of the inspection team. Staff told us that this was likely because without knowing the exact date a discussion around consent to share information had occurred it would be time consuming to scroll through progress notes to find the information. Staff told us that they knew patients well and would not share information without their permission. Most carers we spoke with told us that they had been involved in discussions with the patient around confidentiality and sharing of information. However, one carer told us that they had not been involved in discussing confidentiality and had assumed that staff would share everything with them due to the patient being 14 years of age.

The hospital did not carry out audits to ensure correct application of the Mental Health Act but were in the process of developing an audit tool for monitoring adherence with consent to treatment documentation.

Good practice in applying the MCA

Compliance with Mental Capacity Act training was 87% across both units. Most staff spoken with had a good understanding of the act. However, a member of unqualified staff working on the adolescent unit did not have an understanding of Gillick competence. Gillick competence refers to the test for assessing whether a child under 16 years of age can give valid consent.

The hospital had a Mental Capacity Act policy which was last reviewed in July 2018. The policy made clear the five main principles of the act and referred to Deprivation of Liberty Safeguards. It also referred to Gillick competence and Fraser Guidelines; used for assessing whether a child under 16 years of age can give valid consent. Staff were aware of the policy and knew how to access it. In the six months prior to inspection there were no applications made for Deprivation of Liberty Safeguards.

The staff we spoke with during inspection were clear that patients were assumed to have capacity to make their own decisions. Staff told us that if they had concerns about a patient's capacity to make a particular decision then they would speak with one of the consultant psychiatrists. However, the hospital's Mental Capacity Act policy did not provide details of a named persons or persons whom staff should go to for support and advice.

We saw evidence of discussions around capacity pertinent to a patient who wished to follow a vegetarian diet. On admission this patient was under 16 years of age and documentation showed that prior to admission staff stated the patient did not have capacity to make the decision and that they would act in the patient's best interests when providing her with nutrition. We saw evidence that the patient's capacity was discussed within weekly ward round meetings and that the patient could follow a vegetarian diet once at her target weight as set by staff at the hospital.

Good

Specialist eating disorder services

However, we did not see a documented assessment of the patient's capacity to make the specific decision, or any clear evidence of how staff came to the decision that the patient lacked capacity. Nor did we see evidence of any discussion around best interests and what this would look like for the patient; we simply saw statements suggesting that staff were working in the patient's best interest. The Mental Capacity Act code of practice states that any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision, including documentation of how the decision about the person's best interests was reached, what the reasons for reaching the decision were, who was consulted to help work out best interests, and what factors were considered.

The hospital did not carry out audits to monitor adherence to the Mental Capacity Act.

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

During our inspection we spoke with five patients across the two units. We also spoke with six carers via telephone and collected feedback from 12 patients using comment cards. We observed interactions between patients and staff during ward round and snack time.

Staff were observed to interact with patients in a caring and respectful manner, and we observed staff respond swiftly to offer support to a patient in distress. During ward round staff ensured the patient was involved in deciding who should attend and showed compassion when discussing the patient's background and difficulties. During snack time we observed staff offering encouragement and providing support to patients who were struggling. Staff were always visible in communal areas of the unit and patients confirmed that staff were always available to talk with.

Feedback from patients was mostly positive with patients describing staff as "passionate" and "supportive". One patient commented that they felt the service was superior to other eating disorder services they had experienced and felt that staff "genuinely care". Another patient commented that the hospital "made me want to be alive" and another commented that staff were understanding of the difficulties faced by patients with eating disorders and would act positively when patients had slip-ups rather than chastising them. However, two patients commented that they felt agency staff did not have a good understanding of eating disorders and so could not support them effectively.

Feedback from carers was also mostly positive. They told us that care felt very personalised and that staff were responsive and open with them. One carer told us that staff were very supportive of a patient with a physical disability; ensuring the patient understood their care and showing patience and kindness to them. Another carer commented that they had confidence in the hospital's approach as they felt staff took the time to understand the underlying causes of a patient's illness rather than just treating the symptoms of the eating disorder. However, one carer commented that on one occasion they had observed a staff member speaking in a 'rude' and 'disrespectful' manner.

The involvement of people in the care they receive

Prior to admission patients attended the hospital for an assessment whereby they were invited to meet staff members and to have a tour of the hospital. Patients were also provided with a 'patient handbook' detailing what patients should expect during their stay, therapies and activities available, details of staff at the hospital and information on advocacy and complaints. One patient commented that this process made it easier for them when being admitted.

It was unclear from care plans how involved patients were in this process. One patient told us that care plans were written by nursing staff and would include what staff were doing for the patient. One patient commented that they did not have an up-to-date care plan. When we looked at this patient's record we found that their care plan had not been reviewed since January 2018 even though the review date required was February 2018. Another patient told us that they had had to request a copy of their care plan several times before it was provided. However, patients were more actively involved in ward round and care programme approach meetings. Documentation from these meetings showed that patients were able participate in discussions around their care and that decisions were made in collaboration with patients. Patients told us that therapy was individually tailored to their needs and that staff

Good

Specialist eating disorder services

supported them to maintain independence and build confidence by accompanying them out in the community to places of importance to them, including leisure activities and work placements.

Staff actively encouraged the involvement of families and carers in patient care and family therapy formed part of the treatment at the hospital. Families and carers were encouraged to attend weekly ward round and monthly care programme approach meetings and copies of meeting minutes show clear involvement of families. Visiting times were flexible and staff encouraged families to visit patients regularly. They also told us that staff kept them informed and were responsive to queries and concerns. Families and carers were also offered the opportunity to attend the hospital's 'Maudsley Workshop'; a six-week programme looking at understanding of eating disorders, how to support a person with an eating disorder, and how to facilitate personal wellbeing. Carers spoken with that had attended the workshop commented that it was very helpful.

As part of patients' recovery there was a stepped approach to reintegrating families into patient mealtimes; including encouraging families to attend the hospital to share meals with the patients, and supporting patients to eat meals with their family at home and in the community. Carers commented that this approach helped give them confidence and that they felt supported by staff in this process.

Patients and carers could give feedback about the service and make suggestions for change. Patients could attend weekly peer-led community meetings which were overseen by a member of staff who could feedback issues and concerns raised to the rest of staff team. To ensure all patients felt able to share their thoughts there was a suggestion box in communal areas where patients could write down and post comments anonymously which would then be considered in the community meetings. Community meeting minutes showed patients making requests for items such as new DVDs, and details of these requests being actioned by staff. However, patients on the adolescent unit told us that timescales for action were not always provided leaving patients unsure when requests would be acted on by staff.

Patients were also encouraged to give feedback to the service through a number of questionnaire-style feedback tools on a quarterly basis. Feedback from the Child and Adolescent Mental Health Services Satisfaction Scale (CAMHS-SS) and Verona Service Satisfaction Scale (VSSS), used to measure patient satisfaction in seven areas, showed an increase in patient satisfaction from April to June 2018 compared to results from the previous quarter. Patients were also encouraged to complete feedback questionnaires following Care Programme Approach (CPA) meetings, which asked questions about patient involvement in the process, timeliness of report provision, respectfulness of those in attendance, and support to remain in contact with carers and friends. Senior managers reviewed any scores falling below 75% and created an action plan to improve ratings.

Carers of patients across both units could give feedback through quarterly Family and Friends Tests, and carers of patients on the adolescent unit could also give feedback via the Child and Adolescent Mental Health Services Satisfaction Scale. Results from this survey showed that between April and June 2018 carers were either 'happy' or 'very happy' the care provided.

Patients could get involved in decisions about the service, including the recruitment of staff. Senior managers told us that staff engaged with patients and generated specific meetings to involve patients in considering what they would value in a new staff member. Patients were involved in creating an interview pack with questions based on domains they felt were important. One patient we spoke with told us that they had recently sat on a panel of patients who interviewed prospective staff. The panel provided feedback to senior managers and the patient felt that their opinions were considered.

Patients could access advocacy services and we saw contact details for a local advocacy service contained with the patient handbook which was provided to all patients on admission. We spoke with an advocate who had visited the hospital who told us that visits were positive and that staff involved them appropriately in patient care.

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

Good

Access and discharge

Good

Specialist eating disorder services

Average bed occupancy between 1 October 2017 and 31 March 2018 was 92.2% on the adult unit and 88.4% on the adolescent unit. Patients always had access to a bed on return from leave. All beds at the hospital were commissioned through NHS England. The average length of stay for current patients and patients discharged between 1 April 2017 and 31 March 2018 was 175 days on the adolescent unit and 200 days on the adult unit.

Senior managers told us that they would try to avoid the necessity of moving patients between the adolescent unit and adult unit during treatment by working with adolescent patients to complete their treatment in a timely manner before turning 18 years old. As the adult unit did not accept detained patients, if an adult patient became unwell during their admission and required detaining under the Mental Health Act, staff would work with the patient and their family to find a suitable alternative provision.

Care records did not consistently contain specific discharge plans. However, discharge was clearly discussed at, and documented following, monthly Care Programme Approach and weekly ward round meetings. The carers we spoke with told us that whilst they had not seen discharge plans written down they were aware through verbal discussion of potential discharge dates and plans for patients. We saw evidence in progress notes of discussions with community services around discharge and how patients would be supported back in the community.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment available including a clinic room, patient lounge and designated dining area on each unit. There was also a multipurpose therapy room and a kitchen available on the first floor for adult patients to use with staff supervision. Patients had access to a garden which contained a building with quiet areas available to use for therapies or visitors.

Adolescent patients had access to a school room which was attached to the adult unit. During term-time patients would attend classes if this was deemed appropriate based on individual ongoing presentation. Teachers from the facility would attend ward rounds and care programme approach meetings to give feedback and provide support to patients. At the time of inspection, the school room was closed as it was the summer holidays. The school was too small to be registered for inspection by the Office for Standards in Education (Ofsted) but the hospital commissioned a review from an external consultancy firm. This was last commissioned in January 2018, and whilst a rating could not be provided, the resulting report showed evidence of review of previous recommendations, effectiveness of the management, quality of teaching and future recommendations.

Patients could use their own mobile phones on the unit and in their bedrooms to make calls. Patients could also access telephones on both units where they could make a call in private. The hospital had a spacious garden which patients on the adult unit could access independently based on an individual risk assessment. Garden access was locked for patients on the adolescent unit who were supervised in the garden area at all times.

Each patient had an individual meal planner created by one of two dieticians working with the hospital. Patients told us that food was freshly cooked and that the dietician was very helpful in supporting patients to manage their diet and adapt choices. The hospital had three mealtimes and three snack times each day. Patients were unable to make hot drinks and snacks independently outside of these times but told us that they could ask staff who would provide them with a drink or snack if appropriate to do so in line with their treatment plan.

Patients could personalise their rooms and communal areas of the units. Patients and carers told us that the hospital had a 'homely' feel. Two patients told us that some of the bedrooms on the adolescent unit were 'stuffy' but that the majority were 'really nice'. One of the patients on the adult unit told us that the heating in bedrooms on the top floor of the hospital had exceeded 30 degrees centigrade and that they were unable to open their window fully because of the safety mechanism that had been fitted. At factual accuracy senior managers told us that they offered for the patient to move to a cooler bedroom downstairs and had provided three fans to help reduce the temperature.

Patients had lockable safes in their bedrooms where they could securely store their possessions. Patients on the adult unit had keys to enable them to access their bedrooms throughout the day. Bedrooms on the adolescent unit were unlocked throughout the day unless a patient had been individually risk assessed and this had indicated that their bedroom should be locked in order to

manage risks identified. If a patient without access to their bedroom required access during the day, staff would facilitate this in line with any associated risk which staff assessed on an individual basis.

The hospital ran an activity programme on both units from Monday to Friday. There were no set activities at weekends. Staff told us this was due to many patients going on home leave at weekends. Patients told us staff would engage in activities such as board games at weekends if requested. Patients could make suggestions for activities they would like to engage in and staff told us they would try to facilitate these where possible. Patients were encouraged to fill out individual weekly activity planners detailing hospital run groups they intended to attend as well as groups and activities out in the community. Patients were mostly positive about the range of activities on offer. However, two patients from the adult unit told us they felt there were not enough day-trips available, with one patient commenting that they felt adolescent patients were prioritised.

Meeting the needs of all people who use the service

The hospital was arranged over four floors with a number of staircases. There was a separate wheelchair accessible entrance and lifts located within the building for disabled access. We did not see any information leaflets available in any other languages apart from English, but we did see a handout available to patients detailing interpretation and translation services would be arranged if required.

Information on how to complain was displayed on the units. We saw information on patients' rights displayed on the adult unit but did not see this on the adolescent unit. Information on treatments and therapies available at the hospital was contained within the patient handbook given to all patients on admission.

The hospital could provide a choice of food to meet dietary requirements of religious or ethnic groups. Any foods that patients could not eat were clearly detailed on a dietary information board in the staff office.

Staff told us that they would support patients to access appropriate spiritual support and we saw evidence on patient's weekly planners of planned trips to local churches and a Buddhist centre. The hospital had a room which could be used as a multi-faith space when needed.

Listening to and learning from concerns and complaints

Data provided prior to inspection showed that there were no complaints made to the hospital between April 2017 and March 2018. There was a clear process for patients and carers to make a complaint, with information available on both units and within the patient handbook. This process was outlined in the hospital's 'management of complaints policy and procedure' which outlined timescales and responsibilities for management of complaints. Complaints would initially be dealt with by the relevant ward manager who would look to resolve the complaint locally. If this was not possible then senior managers would commence an investigation. Senior managers also attended 'board to ward' meetings every six months where complaints could be considered at an executive level if required. The hospital had also signed up to 'care opinion' which allowed patients and carers to give anonymous feedback about the care they had received.

Three of the carers we spoke with told us they knew how to make a complaint and would feel able to do so if required. However, one carer told us that they had made a complaint verbally to staff but did not feel this was dealt with. Two patients told us that they had previously made complaints and had received an appropriate response. One patient felt that timescales for investigation were vague but did not state how long their complaint had taken to resolve. The hospital's policy stated that hospital management would endeavour to respond to the complainant within 28 days unless both parties agreed an extension.

Staff told us that feedback on the outcome of investigations of complaints would be discussed within team meetings. We saw evidence within team meeting minutes and senior management team meeting minutes that formal and informal complaints were discussed and actions completed or required were made.

Whilst the hospital's protocol detailed patients' right to contact the parliamentary ombudsman if they were unhappy with the outcome of a complaint investigation, this detail was not contained within the hospital's complaints policy, or in complaint response letters that were sent out.

Are specialist eating disorder services well-led?

Good

Specialist eating disorder services

Good

Vision and values

The hospital had a clear vision and values which were displayed in staff areas. Values were care, compassion, competence, communication, courage and commitment. We saw staff demonstrate these values in their engagement with patients. Senior managers told us that these values were embedded within staff appraisal documents to ensure objectives reflected the hospital's values.

Staff told us that senior managers were visible within the hospital. Staff highlighted that they felt able to approach senior managers for advice and support.

Good Governance

The hospital had a clear governance structure in place. The senior management team met once a week to discuss one of four topics including governance, policies and procedures, training and recruitment, and estates, infection prevention, health and safety; meaning that each topic was a focus once a month. This allowed the senior management team to have oversight of areas including staff training, supervision and appraisal, medicines management, estates, audits, complaints and compliments, and incidents and investigations. The hospital also used a number of key performance indicators to measure quality and safety. These included restraint, beds usage, serious incidents, complaints, and outcome measures. The senior management team discussed these indicators during senior management team meetings and reported on governance and key performance indicators to the board on a quarterly basis.

However, some governance systems did not appear to be entirely effective. Despite oversight of both internal nurse audits and external pharmacy audit with regards to medicines management we found ongoing concerns regarding the completion of patient medication cards. In addition, mandatory training compliance was still low in some areas despite senior managers being aware of concerns following a previous inspection.

Information relating to patient care was largely stored on the hospital's online system, but we found that some patient information, including printed care plans, were also stored in files in the nurses' office on the unit. Whilst these files were stored in a room requiring staff fob access, they were not stored in a locked facility and therefore could have been accessed by any employee with fob access, including staff with no clinical reason for accessing such information.

The hospital had a risk register. Senior managers told us staff were unable to submit items to the risk register but could raise any relevant concerns during staff meetings. Staff spoken with were unsure what the risk register was but confirmed that they would raise any concerns around risk with senior managers.

There were policies in place specifically related to eating disorders, including refeeding guidelines, prevention and management of disturbed behaviour, and enteral feeding guidelines, and staff were aware of where to find these policies. However, further policies specifically related to the care of patients with eating disorders, including prevention and management of suicide and self-harm, and nutritional supplements, were still awaiting ratification by the board at the time of inspection. Following inspection senior managers told us that these policies had been reviewed by the board and were scheduled to be ratified imminently following minor amendments suggested by the board. Further to this, we could see that concerns around suicide and self-harm were acknowledged within pre-existing observation and risk policies which meant staff could refer to these policies for advice and support whilst awaiting the ratification of the more specific policy.

Leadership, morale and staff engagement

The hospital undertook yearly staff surveys. At the time of inspection staff had been invited to attend forums to discuss the most recent survey results collected. Whilst not yet available during inspection, senior managers told us that they were awaiting the aggregated findings of these focus groups in order to develop a 'you said, we did' report. The staff we spoke with told us that morale was high and they felt well supported and respected by the team. Senior managers told us that they valued staff and showed this is a variety of ways including provision of staff away days and 'recognition boxes', where staff could post positive comments about their peers.

At the time of inspection there were no reported cases of bullying or harassment being investigated by the hospital. Staff spoken with were not aware of any issues regarding

bullying or harassment. Between 1 April 2017 and 31 March 2018 overall staff sickness was 3.8% on the adult unit and 5.5% on the adolescent unit. Senior managers felt that sickness levels were generally low.

Staff spoken with told us they would feel able to raise concerns without fear of victimisation and knew how to use the whistleblowing process if required. During inspection we saw posters around the hospital advertising details of the Freedom to Speak Up Guardian. However, out of six staff members asked, only two were aware that the hospital had a Freedom to Speak Up Guardian and could tell us who that person was.

Staff told us that there were opportunities for development within the hospital. For example, a nurse was being supported to access a development post to allow them to build on specific skills required for a more senior role within the hospital.

Staff followed hospital policy regarding openness and transparency by explaining to patients if and when something went wrong. For example, a patient was given a higher dose of medication than was prescribed. The incident was reported and the patient received an explanation and an apology.

Staff told us they could give feedback on the service and input into service development via regular staff meetings and away days. We saw minutes from an away day for staff on the adult unit and saw that staff were engaged in discussion around care programme approach meetings and what these should include.

Commitment to quality improvement and innovation

The hospital was engaged in a number of projects aimed at improving the service. Some of these projects included;

- The hospital was first accredited by the Royal College of Psychiatrists Quality Network for Eating Disorders (QED) in April 2014. Accreditation involved being peer reviewed by staff from other eating disorder services, and peer reviewing other services, to encourage improvement by learning from others, and to ensure quality in eating disorder service provision. At the time of inspection, the hospital was awaiting a review appointment in order to maintain their accreditation.
- The hospital was also running a social enterprise called 'by Riverdale'. This social enterprise aimed to encourage patients to engage in a range of activities in order to raise awareness of eating disorders in the local community. We saw a range of items on sale which had been made by patients, including chutneys and boxes of cards. We also saw patients going out into the community as part of a photography group; taking photographs which would then be turned into cards for future sales. Patients told us that they had been able to grow their own produce in the hospital garden which they had then used to make jams and chutneys.
- Senior managers told us that the hospital had recently been involved in research alongside a professor from a local university, looking at the correlation between patient's body mass index (a measure of healthy weight) and attitude towards eating disorders at different stages of treatment. The paper was awaiting publication. Senior managers also told us that the hospital had good links with another local university whereby qualified nurses and recovered patients from the hospital provided eating disorder awareness training to all mental health student nurses at the university.
- Whilst not in place at the time of inspection, staff told us about several additional innovative projects they were currently working on. Firstly, the hospital's webpage was in the process of being rebuilt to include up-to-date content. Senior managers told us this should be ready for launch online in September 2018. Secondly, staff told us that they were looking to introduce the option for video conferencing to patient care programme approach meetings, to allow those finding it difficult to attend in person to contribute to the meeting. Finally, staff told us that they had been approached by a production company to film a documentary about eating disorders and were in the process of finalising details for this.

Outstanding practice and areas for improvement

Outstanding practice

- Staff at the hospital were working with patients to run a social enterprise aimed at raising awareness and understanding of eating disorders within the local community. Patients were engaged in making products to sell within the community, with any profits being spent on materials for future projects.
- Staff from the hospital were involved in providing education sessions to student nurses at a local university; to give an insight into how the service cared for patients with an eating disorder. This was the only specific insight into eating disorders that those students received whilst at university.
- Families are carers were invited to attend 'The Maudsley Programme'; a series of sessions aimed at education around eating disorders as well as providing peer support.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are completing patient medication cards following administration of medication with the relevant information required.
- The provider must ensure that staff are up-to-date with mandatory training.

Action the provider SHOULD take to improve

- The provider should ensure that all equipment contained within emergency bags is documented correctly.
- The provider should ensure that adolescent patients are individually risk assessed in relation to supervision when accessing the adolescent garden.
- The provider should ensure that patient rights under the Mental Health Act are clearly displayed on the adolescent unit.
- The provider should ensure that all patients are involved in discussions around consent to share information, and that decisions in relation to this are documented clearly and are accessible to all relevant staff when required.
- The provider should ensure there where there are concerns or queries related to a patient's capacity to consent to a specific decision that there is a documented assessment of patient's capacity to make a particular decision in line with the Mental Capacity Act code of practice.
- The provider should ensure that contact details for the Parliamentary Ombudsman are detailed within the hospital's complaints policy, and complain response letters.
- The provider should ensure that patient care-plans contained within paper-based files are complete and up-to-date.
- The provider should ensure that fridge temperatures are accurately measured and documented to ensure ongoing compliance with temperature range recommendations.
- The provider should continue to ensure that emergency medication is stored in line with manufacturers guidance.
- The provider should ensure that their fire safety risk assessment is amended in line with changes made to fire exits.
- The provider should ensure that patient information is stored securely.
- The provider should ensure that effective governance systems and processes are in place to manage concerns identified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff did not consistently complete patient medicine cards accurately following medication administration Not all staff were up to date with mandatory training pertinent to their role, specifically eating disorder awareness training This is a breach of regulation 12(1)(2)(b)(c)