South West London and St George's Mental Health NHS Trust

Specialist eating disorders services

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RQY01	Springfield University Hospital	Avalon ward	SW17 7DJ

This report describes our judgement of the quality of care provided within this core service by South West London and St George's Mental Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South West London and St George's Mental Health NHS Trust and these are brought together to inform our overall judgement of South West London and St George's Mental Health NHS Trust.

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

The service had a clear action plan in place that focused on improving the care and treatment provided to patients on the ward. There had been improvements in the ward environment and there was an ongoing programme of refurbishment.

The ward admitted patients from across the country and was able to care for patients with complex health needs, through the provision of high dependency beds.

There were systems in place to ensure that learning from incidents took place throughout the service.

Feedback from patients using the service was generally positive. Patients' voices were evident in their care plans. They participated in meetings and received information about their care. Staff took patients' views into account when appropriate when planning individualised meals.

There was evidence of collaboration between patients and staff. They had worked together to produce a therapeutic eating charter and other information highlighting best practice in care for patients with eating disorders.

The service used a range of outcome measures to determine the efficacy of the care and treatment provided. Staff had working lunches to discuss how best to support and care for patients.

There was a strong focus on original research to improve the care and treatment of patients using the service. The patients and multi-disciplinary team contributed to the work of the St George's University of London Eating Disorders Research Committee.

Avalon ward had nursing vacancies and there was regular use of agency staff. Recruitment was a priority for the trust and there was an ongoing recruitment campaign.

However, not all staff had completed required statutory and mandatory training or updates of training. Overall, 46% of permanent staff had completed their required training. There were significant shortfalls in fire safety awareness training, basic life support techniques and medicines management training.

Patients' risk assessments were not always updated after incidents, which meant that staff might not be able to respond appropriately.

Results of checks on the physical health of patients were not always up dated promptly in patients' electronic records. There was a risk that staff would not escalate concerns to medical staff quickly.

The cleaning records for the ward clinic rooms were not up to date and the rooms and equipment were dusty. A clinical specimen had been stored in the same fridge as medicines and there was a risk of contamination.

Staff had not always checked emergency equipment every day to make sure it was fit for purpose.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

- Many staff had not completed essential training in adult life support, medicines management and fire safety awareness which meant they may have lacked key knowledge and skills needed to care for patients safely.
- Patients' risk assessment and management plans were not always updated after an incident, which meant that staff might not be aware of new risks affecting the patient.
- Information on patients' physical health was not always transferred promptly onto their electronic care records, which meant that there was a risk that staff may not have escalated concerns quickly.
- Staff had not always completed daily checks on the emergency equipment to make sure it was fit for purpose.
- A clinical specimen was stored in the same fridge as medicines and there was a risk of contamination.
- The clinic rooms and the equipment inside were dusty and the cleaning logs were incomplete.
- The ward was undergoing refurbishment and the communal areas of the ward appeared cluttered. There were confidential waste bags in the corridor that had split open. The contents were on the floor and this represented a trip hazard

However:

- There were planned admissions onto the ward, which meant that staff had an understanding of patients' needs prior to their admission.
- Patients had a comprehensive risk assessment and care and management plans completed on admission.
- There were doctors available to attend the ward day and night in an emergency.
- The trust was actively recruiting for nurses. Shortfalls in staffing were covered by long-term agency staff to provide continuity of care.

Are services effective?

- Staff completed comprehensive assessments of patients after admission. These assessments included patients' physical health.
- Ward rounds were held weekly. Patients were able to attend these meetings to discuss their care and treatment.
- Patients had individualised meal plans. They met with the dietician to discuss these plans.

Summary of findings

- Patient care records were stored securely. Staff could access this information when needed.
- National guidance was considered when prescribing medication and providing specialist treatment.
- The ward provided a range of therapeutic groups for patients.

Are services caring?

- Staff were caring and respectful. They interacted well with patients.
- Patients were mostly complimentary about the staff.
- Community meetings were held daily. These meetings were attended by all grades of staff and patients and enabled patient involvement in the service.
- Patients and staff worked together to produce guidance regarding supporting patients with eating disorders
- A welcome pack was given to patients when admitted. The welcome pack contained useful information about the ward and the advocacy service.
- Patients were able to give real time feedback about the ward. The feedback was reviewed by the trust and the patient received a personalised response.
- Patients felt supported by individualised meal plans.
- Parents and carers could attend the monthly carer's support group.

Are services responsive to people's needs?

- All admissions onto the ward were planned.
- The ward had three high dependency beds. This meant that patients with complex health needs could be cared for.
- Discharges were not delayed wherever possible. Leave was increased for patients in preparation for discharge.
- The ward worked closely with care-coordinators and liaised with them regarding discharging patients back to their home area.
- The ward could provide patients with diets that met their cultural and religious needs. The social work team worked closely with families. They understood the impact and importance of food in different cultures
- The ward was undergoing refurbishment. A new lift had been installed and the ward was accessible to those with mobility issues.
- The ward provided a range of activities for patients.

Summary of findings

Are services well-led?

- The ward manager was complimentary about her team. The staff on the ward described a supportive team.
- There was a comprehensive action plan in place to improve the ward, which was reviewed regularly. The action plan had led to the implementation of a number of regular meetings during which staff could meet discuss their practice.
- Managers met to discuss how to improve patient care and treatment. There were regular leadership forums.
- The ward was involved in an accreditation process, to demonstrate that they were delivering quality care and treatment to patients with eating disorders.
- There had been an audit of care plans. This identified the improvements that staff needed to make.
- Staff felt able to raise concerns and knew about the whistleblowing policy.
- Staff and patients were involved in research. Patients were experts by experience and provided input into the research undertaken by St George's University of London Eating Disorders Research Committee.

Summary of findings

Information about the service

Avalon Ward is a national, specialist service providing care and treatment for male and female patients over the age of 18, experiencing severe eating disorders. There are currently 18 inpatient beds on the ward.

The usual length of admission is three to four months. The ward had a mixture of detained and informal patients at the time of the inspection.

The last inspection of the service was in March 2014. At the time the service was meeting essential standards, now known as fundamental standards.

Our inspection team

The team comprised of: an inspection manager, two inspectors, a specialist advisor with experience of working in eating disorders services, and an expert by experience, who had experience of using services

Why we carried out this inspection

This was an unannounced focused inspection. Concerns had been raised in April 2015 regarding the care and treatment of patients. We undertook this inspection to check that the concerns had been addressed.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about this service. After the inspection, we also asked the trust to provide us with additional information to enable us to make our judgements.

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 Avalon ward at Springfield University Hospital and looked at the quality of the ward environment
- observed how staff were caring for patients.
- spoke with eight patients who were on the ward.
- spoke with the manager of the ward.
- spoke with and received information from 12 staff members; including doctors, nurses, an occupational therapist and psychologists.
- interviewed the modern matron with responsibility for this service.
- attended the ward community meeting.
- looked at five care records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider's services say

We spoke with eight patients. The majority told us that they received good care and treatment from staff. They were complimentary about the multi-disciplinary team (MDT) that supported them.

Three patients felt that the individualised meal plans provided by staff were helpful in promoting their recovery and care.

One patient said that the service was valuable. They felt that the staff were able to work effectively with patients who had complex needs. A number of patients felt that the daily community meetings were useful. It gave them the opportunity to discuss concerns.

Patients were proud of the work that they had undertaken to co-produce the therapeutic eating charter with the multi–disciplinary team led in this case by the lead psychotherapist. This charter gave guidance on how patients and staff could support each other in the dining room during meal times.

Some patients were concerned about the staffing shortages and the reliance on agency staff. A number said that agency staff were not always experienced in working with patients who had eating disorders and this sometimes led to an insensitive approach. Patients commented that the refurbishment works on the ward had caused disruption and dust.

Good practice

- Patients and staff had co-produced a number of publications designed to inform staff on how best to support patients with an eating disorder.
- The psychological therapies team were participating in research in conjunction with St George's University of London Eating Disorders Research Committee.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff complete mandatory training in adult basic life support, medicines management and fire safety awareness.

Action the provider SHOULD take to improve

- The provider should ensure that patient risk assessments and management plans are reviewed and updated following risk incidents.
- The provider should ensure that clinic rooms are kept clean and tidy. This is to ensure that patients are protected against the risk of infection.
- The provider should ensure that clinical specimens are not stored in the same fridge as medicines.
- The provider should ensure that information about patients' physical health care is transferred promptly on to patients' electronic records so that it can be followed up quickly when concerns are identified.
- The provider should ensure emergency equipment is checked everyday to make sure it is fit for purpose.

South West London and St George's Mental Health NHS Trust

Specialist eating disorders services

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Avalon ward	Springfield University Hospital

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.

- Fifty six per cent of staff had been trained in the Mental Health Act. Care records showed that patients had their rights under the Mental Health Act explained to them.
- The mental health documentation we reviewed was completed and stored appropriately.
- Independent mental health advocacy services were available for patients who were detained.
- Patients' consent to treatment was recorded on their health care records.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Fifty six per cent of staff had been trained in the Mental Capacity Act 2005 (MCA). Staff we spoke with had an awareness of the importance of assessing patients' capacity to consent.
- There was evidence of capacity assessments in patient records.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Avalon was a mixed gender ward. The ward had 18 beds including four beds for patients with high dependency needs. The ward was able to care for patients with complex physical health needs as a result. There were no male patients on the ward at the time of the inspection.
- The ward complied with guidance on same-sex accommodation. There were separate corridors containing bedrooms for male and female patients. There were separate lounge areas for male and female patients.
- Refurbishment works were taking place, including the installation of new bathrooms. The provider had consulted with patients about the work. Some staff felt that the impact of the work on patients had been under-estimated. Both staff and patients said that the building works had created a lot of dust and noise but liked the improvement in the ward environment.
- There were items of furniture in one corridor that were awaiting removal. Some parts of the ward appeared cluttered and untidy.
- There were two confidential waste bags in the corridor outside the community room. One of the bags had split and the contents were spilling out. There was a risk of breaches of confidentiality as well as the contents on the floor being a potential trip hazard.
- We found a urine sample that was dated 1 October 2015 in the fridge in clinic room one. It was stored alongside medication and presented a risk of contamination. It had been in the fridge for 14 days. When we pointed this out to staff, the sample was removed.
- Staff carried out infection control audits routinely every 18 months. The trust had delayed the next audit until the completion of the building works.
- Staff carried out monthly audits of ward cleanliness. The most recent audit of cleaning dated October 2015 identified that there were 16 cleaning failures on the ward, 50% of these were due to an accumulation of dust. After the inspection, the trust assured us that domestic staff were cleaning to a higher standard.
- There were two clinic rooms and a medical room on the ward. These were rooms where specialised treatment could be undertaken, for example, nasogastric feeding and physical health checks. These areas were disorganised and unclean. There were no cleaning schedules available. The equipment did not have labels attached to them stating when they had last been cleaned. Nursing staff seemed unclear as to who was responsible for cleaning and thought that it was the responsibility of the domestic staff. There was not an identified nurse in charge of the clinic rooms.
- Thick brown paper bags were used for the collection of non-clinical waste on the ward. The trust had introduced these as a safety measure. There were no plastic bags allowed on the ward in areas accessible to patients due to concerns regarding patient safety. Patients raised concerns regarding the infrequent replacement of the paper bags. They said that housekeeping staff tended to empty the rubbish from the paper bag and leave it in place rather than removing and replacing the bag with a new one. There was potential for the bags to disintegrate and smell due to infrequent changing.
- Staff did not record room and fridge temperatures in clinic room one on a daily basis. The fridge was used for storing medicines. Between the beginning of August 2015 and the end of September 2015 the fridge temperature should have been recorded 62 times but it was recorded 38 times. Storing medication at the right temperature helps ensure its effectiveness.
- Staff were required to carry out checks on emergency equipment every day to make sure it was fit for purpose. However, we found a number of gaps in the records. The equipment should have been checked on 62 occasions. between the beginning of August 2015 and the end of September 2015. There had been no checks recorded on 28 days in that time period.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The staff managed environmental risks in the communal areas and bedrooms. A ligature risk assessment had been completed in September 2015, and plans were in place to mitigate the risks identified. Staff observed patients who were at risk of self-harm more closely. Some bedrooms had fewer ligature anchor points. These were used for patients at greater risk of self harm.

Safe staffing

- There were doctors available to attend the ward day and night in an emergency. Staff could also seek advice from an on-call nurse and consultant should this be required. Information regarding who was on call was available to staff.
- The trust had set safe staffing levels on the ward for all shifts and these were usually met. There were two vacancies for deputy managers, five vacancies for band 5 nurses, and two vacancies for health care assistants. There were three vacancies in the multi-disciplinary team. Recruitment was a priority for the trust and there were monthly recruitment initiatives. There was a newly appointed deputy manager and health care assistant and the ward was waiting for them to start. There had been a 30% - 40% turnover of staff in the six months prior to the inspection.
- The ward had used the same regular agency staff for several months to cover the staff shortages. This helped ensure continuity of care. . The ward manager and the patients were positive about the agency staff who regularly worked on the ward.
- Staff expressed concern regarding the difficulties in recruiting permanent staff. The trust used a risk evaluation tool (SiREN) to identify teams that required support. The SiREN report completed for the ward in October 2015 noted that the team was “under significantly more stress than usual but coping” due to the recruitment difficulties.
- Patients told us the ward had high numbers of male agency staff, especially in the evening and at night. Two female patients expressed concern regarding male staff observing them in their rooms at night whilst they slept.
- Staff who were new to the ward were provided with an induction to orientate them to the ward layout, safety issues and routines. However, one permanent staff member stated that inductions onto the ward did not always take place for staff and this was due to work pressures. During the inspection, we spoke to two staff members. One agency nurse had received an induction to the ward while the other, a permanent health care assistant, had not. The health care assistant was not aware of the location of the emergency resuscitation equipment on the ward. This presented a potential risk to patient welfare.
- Staff had a programme of statutory and mandatory training. However, not all staff had completed their training requirements. The completion rate for adult basic life support for inpatients was low with a completion rate of 18%. Twelve staff required training in medicines management (inpatient). However, only three staff had been trained (25%). Thirty-four staff were supposed to have received training in fire safety awareness (inpatient) training, only eight staff had received this training (24%). This meant not all staff were appropriately trained to provide appropriate care and treatment to patients.

Assessing and managing risk to patients and staff

- The ward had a weekly bed-planning meeting to discuss new admissions and to plan for them.
- Patients were risk assessed on admission. Staff used a standardised risk assessment tool that was stored electronically and accessible to all staff. We reviewed the care records of seven patients. We found completed risk assessments and risk management plans for all seven patients. However, in two cases there was no update of risk after an incident. The lack of update could mean that staff would not be aware of how best to mitigate the risk posed to patients.
- Records of the use of restraint and supportive holds were available. The records indicated the reason for and duration of restraint. There were 17 incidents of restraint on the ward between March and August 2015. Eight of these took place in August and related to one particular patient.
- Most staff told us they had received training in de-escalation techniques and proactive preventive interventions, which included how to safely restrain a patient with low body mass index.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The ward had designated visiting times and vulnerable visitors, for example, children were restricted to the visiting area to ensure their safety.
- The social worker allocated to the ward had provided safeguarding training to the staff. A safeguarding alert had been raised in April 2015. The local authority stated that the trust had responded promptly.
- We reviewed six medicine administration records. Of the six records one record did not have a review of the patient's "as required" medication (PRN) which prescribed to them when needed. There had been no review of the PRN medication for 14 days for this patient. NICE guidance (NG10) recommends that the multi-disciplinary team should review a patient's PRN medication at least once a week.
- Staff checked patients' vital signs on a regular basis to ensure prompt identification of potential physical health problems.The results of the checks were recorded on national early warning scores (NEWS) charts.
- We reviewed the NEWS charts of nine patients. There were records missing for four days in October 2015 for eight patients. On three occasions, the information on the charts were incomplete. For one patient there were duplicate records.
- The electronic monitoring system had not been updated immediately with information from the NEWS charts. Staff had recorded the information on pieces of notepaper and filed them in the NEWS folder. By not entering the clinical readings on to the NEWS chart contemporaneously there was a risk that the need to escalate concerns about a patient's physical health to a doctor would not be recognised or acted on.

Track record on safety

- There had been 216 incidents on the ward between January 2015 – September 2015. There were a broad range of incidents reported which included incidents related to the environment, patients and staff. Nineteen per cent of incidents were medicines errors, 15% were incidents of self harm and 5% were related to patient's attempting to abscond or absconding from the ward.
- None of the reported incidents had been categorised as serious.

Reporting incidents and learning from when things go wrong

- Following a safeguarding concern in April 2015, the trust had reviewed the care and treatment provided by the ward. They had implemented a comprehensive plan of action to improve the functioning of the ward. There had been a review of the operational policy. There was now a greater emphasis on promoting a recovery focused and effective delivery of care.
- The ward manager and modern matron told us how they maintained an overview of all incidents reported on the ward.
- There had been training for the staff team on incident reporting.
- The manager was able to give an example of how staff had implemented learning from incidents. One incident related to an occasion where a patient had self-harmed whilst on the ward. Afterwards the policy on searching for contraband substances was revised
- There was further evidence of learning and change. As a result of a patient filming activity on the ward in April 2015, there was a newly revised mobile phone policy that banned the use of smartphones. Smartphones have the ability to film others and can allow users to access websites that might not be conducive to their recovery. There was training for staff on how to challenge patients appropriately if they observed the use of smartphones.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Staff carried out comprehensive assessments of patients on admission to the ward. The assessment included a physical examination, which included blood and urine tests.
- We reviewed the care plans of seven patients. Five care plans noted the patients' views. These plans were holistic and well structured.
- Patients had individualised meal plans. The dietician and patient worked collaboratively on these plans. Patients praised this aspect of their care and felt that it contributed to their recovery.
- Patient information was stored on an electronic records system. This allowed easy access to information.

Best practice in treatment and care

- The doctors considered NICE guidelines when prescribing medicines. Treatments for eating disorders were based on national guidance.
- The ward staff assessed patients using the health of the nation outcome scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of patients' responses to interventions. The ward completed this at the beginning and end of treatment to measure progress.
- Staff provided a range of evidence based interventions to support patients' recovery. This included both one to one interventions and groups. Interventions included family therapy, cognitive behavioural therapy, psychodrama and psychotherapy.
- The newly appointed occupational therapist (OT) had restarted therapeutic groups for patients. The group programme included a relapse, recovery and reflective group – patients reflected on the previous week and set goals for the next; a 'have a go' group – a social engagement and activity group (named by the patients); a meal preparation group for those ready to make their own meal – including meal planning, shopping and cooking. The OT consulted patients about their interests and therapeutic needs to revise the group programme.
- The OT used the model of human occupation screening tool to assess patients and measure their progress. The eating and meal preparation skill assessment (EMPSA) was also used as an assessment and outcome measure. The EMPSA measures patients' perceptions of their eating and meal preparation skills before and after meal preparation interventions.
- Patients had individualised meal plans that complied with national guidance.

Skilled staff to deliver care

- The staff working on Avalon came from a range of professional backgrounds including nursing, medical, occupational therapy, psychology, psychotherapy, social work and dietetics. Other staff provided support, including a physiotherapist and a phlebotomist.
- The ward used several agency nursing staff. Not all of these staff were experienced in caring for patients with eating disorders. Most bank and agency staff had received training in how to use the electronic records.
- The OT received weekly supervision from the manager of the eating disorders day service who was also an OT.
- Supervision for nursing staff had been irregular between April and July 2015. However, there had been improvements in this. Nursing staff had received regular supervision from August 2015 onwards.
- Ward staff had ongoing training via supervision and reflective practice in psychosocial interventions. There had also been training in disability awareness and applying mental health law for staff.
- Staff had working lunch sessions/reflective practice sessions. This gave an opportunity for staff to discuss complex cases and devise strategies to support patients. The sessions helped to improve patient care and team working. Training sessions were relevant to the work undertaken by staff. Staff commented that the reflective practice group was useful and gave staff an opportunity to look at some of the recurrent themes that arose out of working with this patient group.
- The ward manager stated that nursing staff had difficulty accessing the reflective practice sessions due

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

to work pressure and the 12-hour shifts they worked. Staff were attending half the session so that they would not be away from the ward for too long. As a result, staff did not get the full benefit of reflective practice.

Multi-disciplinary and inter-agency team work

- There were weekly care plan review meetings (ward rounds) involving the multi-disciplinary team (MDT).The patient attended these meetings.
- The team used teleconferencing as a way of involving patients' care co-ordinators in discussions about care and treatment. This was particularly helpful for patients whose care co-ordinators were not based locally.
- Handover meetings took place at the change of the shift. Members of the MDT joined this meeting and the ward consultant attended twice a week. There was good information sharing regarding patient progress during this meeting and discussions regarding key-working sessions took place.

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

- Fifty six per cent of staff had been trained in the Mental Health Act. Care records showed that patients had their rights under the Mental Health Act explained to them.
- The mental health documentation we reviewed was in order and stored appropriately.
- Independent mental health advocacy services were available for detained patients. The ward notice board displayed advocacy information.
- Consent to treatment was recorded on the patients' records.

Good practice in applying the Mental Capacity Act

- Fifty six per cent of staff had been trained in the Mental Capacity Act 2005 (MCA). Staff we spoke with had an awareness of the importance of assessing patients' capacity to consent.
- There was evidence of capacity assessments in patient records.
- The social worker had provided training for staff on MCA and deprivation of liberty safeguards.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff spoke respectfully about patients and showed concern for them.
- Patients felt that the majority of staff were caring. One patient commented that the consultant knew them and understood their clinical needs.
- Eight patients we spoke with were complimentary about the staff and the care delivered on the ward. Patients described the ward team as “friendly” and “compassionate”. They described the psychological therapies team including psychotherapy as “excellent".
- The patients had written “Food for Thought – A Glimpse into the World of Eating Disorders: An Avalon Patient Guide for those who work with them” (2015). This guide gave in-depth information on the patient experience for staff who were working on the ward.
- There was a “staff thank you” board on the ward. Patients had attached positive messages to this board. There were a number cards praising the staff.
- Patients felt that their individualised meal plans helped their recovery.
- Two patients said that some agency staff were not always respectful and did not knock before entering their rooms. One patient was concerned about her privacy and told us she now routinely hid behind her wardrobe to get dressed.

The involvement of people in the care that they receive

- Newly admitted patients had a welcome pack. The patient welcome pack contained information on the advocacy service, consent to treatment, advance statements, confidentiality and information sharing.
- Patients were involved in their care plans. There was evidence of patients’ views recorded on the electronic records.
- Patients could give real time feedback on a tablet computer. The feedback was confidential. Patients could comment on the care they received and other issues for example, the ward environment. We reviewed 28 pieces of feedback provided over a three-month period. The trust responded to 24 items of feedback within 15 days.
- Staff had displayed comments about the ward on the wall near the real time feedback device. This included a display of what patients had said and what staff had done about it from July and August 2015.
- There was a patient noticeboard in the ward corridor. This displayed information for patients. For example, there was information for informal patients that explained their rights and what patients could expect with regards to their treatment.
- Ward based community meetings were held daily. These meetings were attended by staff and patients and gave the opportunity for patients to express their views. Staff said that they were committed to improving the service for patients.
- Staff and patients had worked together to produce a charter for therapeutic eating which was on display in the dining room.
- The social work team held a monthly carer’s group and provided one to one work with families and carers. The social worker responded to the needs of carers and offered Saturday and evening appointments. They supported carers to prepare questions for meetings with the consultant psychiatrists. The carers group provided support and education to family members in respect of eating disorders.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The ward operated a national eating disorders service and some patients came from outside of London. The ward had three high dependency beds for patients who required additional nursing care.
- Planned admissions onto the ward took place. The ward had a weekly bed-planning meeting.
- When patients went home on leave, their in-patient bed was kept for them.
- Discharge planning started early. The ward manager stated that a lack of provision in local areas sometimes delayed discharges. Some patients had been on the ward for over two years due to their individual needs and no beds being available in their home area. Staff told us they liaised with patients' care co-ordinators to make sure a suitable placement and follow up arrangements were in place after discharge. Patients' care co-ordinators were sometimes involved through the use of tele-conferences. This reduced the need for care co-ordinators to travel long distances and ensured their participation in care planning meetings.
- The social worker facilitated and supported the transfer and discharge of patients. The social worker provided regular updates to local teams and co-ordinators about patients' progress.
- Patients had increasing amounts of leave from the hospital in preparation for discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- Patient bedrooms were personalised and patients were able to keep their belongings safe and secure. Bathroom and toilet facilities were separate. This helped staff observe patients after meal times when there were particular risks related to their condition.
- The ward provided a full range of activities, which were also available at the weekend.
- There was a range of rooms and equipment to support patient treatment and care, including clinic rooms and quiet lounge.
- Patients could use mobile phones if they wished. The trust had a policy in place to promote the appropriate use of mobile phones and prevent patients using smartphones inappropriately. Patient's mobile phones were removed if other patients were put at risk.
- Patients had access to a garden. There was a lift available for those who had impaired mobility.
- There were set meal times on the ward. Patient meal plans were individualised and developed collaboratively by staff and patients. There was clear guidance around appropriate food groups. There was no exclusion of an entire food groups unless there was a clinical reason. Staff supported patients during meal times.
- Food was pre-packaged and reheated in the ward kitchen. Three patients commented that the food was not always of good quality and that vegetables were overcooked and unpalatable.
- There was a process for ordering nutritional supplements for patients and staff checked stock levels on a weekly basis.
- Patients had access to drinks and snacks throughout the day and evening.

Meeting the needs of all people who use the service

- The ward was on the second floor. People with mobility difficulties, could access the ward via a lift. The OT was the disability champion for the ward. Prior to the refurbishment of the ward, there had been an assessment of accessibility, particularly for wheelchair users. The ward would be re-assessed once the refurbishment was completed. There was an improvement in bathroom accessibility for patients.
- There was easy access to interpreters and signers for patients who needed support to communicate with staff. The OT was due to undertake training to become the accessible communications champion.
- The ward was able to provide food to meet the dietary requirements of differing religious and ethnic groups.
- The social worker described working closely with South Asian families and appreciated the impact and importance of food in different cultures.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- The ward provided information on a range of services including legal services, advocacy, B-eat (an eating disorders charity) and the trust's complaints process.
- There was also a poster designed by patients and displayed on the ward entitled "Things that should never be said to a patient". It had helpful tips for staff who worked on the ward

Listening to and learning from concerns and complaints

- There had been 12 complaints in the last 12 months. Eleven complaints were not upheld. Three complaints were regarding poor communication, two patients had complained about staffing levels and one concerned poor quality of care. The response to these complaints was appropriate.
- Learning from complaints was shared with staff.
- As well as using the formal trust complaints process, patients were also able provide feedback through the real time feedback machine on the ward.
- We spoke with one patient who had made a complaint but did not know the outcome of their complaint. We raised this with the ward manager who agreed to follow this up with them.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- Managers spoke with enthusiasm about the values of the trust and the implementation of them in the team. One manager emphasised the importance of working in collaboration, being respectful and offering the best care possible to patients.
- Some senior members of the management team had visited the services.
- The ward manager attended a collective leadership forum. The forum looked at developing a leadership strategy. It focused on six key areas, which included team culture, organisation mission and values. The forum sought to promote good practice and co-production with staff and patients.

Good governance

- There had been a number of issues of concern on the ward and an action plan was in place. The management team were aware of these challenges. They were working to make positive changes.
- There had been improvements on the ward and there were regular reviews of the action plan. Reviews were undertaken in conjunction with NHS England and the trust. The operational policy for the ward had been reviewed and revised and had a greater emphasis on recovery. Staff and patients commented positively on the changes that had taken place on the ward.
- The ward manager and the modern matron met weekly to discuss the ward and identify emerging issues of concern.
- There were systems or processes established to ensure the quality and safety of the service was assessed, monitored and/or improved. There was good use of the SiREN reports, which enabled the trust to respond to issues of concern on the ward. Audits had taken place around care planning and plans were in place to improve the quality of these.
- There were some new policies on display in the staff office. Staff signed to confirm that they had read and understood the policy.
- Staff mandatory training completion rates were low with an overall completion rate of 46%. There were significant shortfalls in some areas of essential training.
- The ward had a number of vacancies. There were high numbers of agency staff. The service was actively recruiting new staff.
- The trust had a risk register. The ward manager said that some staff were aware of it but might not be aware of the process of entering information on to it. Staffing and the 12-hour shift pattern were identified risks on the risk register.

Leadership, morale and staff engagement

- The ward manager said that staffing difficulties had contributed to lower staff morale. However, our discussions with staff did not reflect this. Staff were enthusiastic about their role.
- The modern matron visited the ward several times a week. Other members of the senior management team visited the ward occasionally. They had visited the ward to carry out a “15 Steps Challenge”. The “15 Steps Challenge” helps organisations gain an understanding of how patients feel about their care. It can also help them understand and identify the components of high-quality care that are important to patients.
- There was information regarding the staff whistle blowing policy on the trust intranet. The staff we spoke to said that they would feel able to raise concerns.
- The ward manager felt well supported by her manager. She had received leadership training.
- Different disciplines spoke very highly of each other and understood the different roles staff had. The multi-disciplinary team met regularly to discuss patient care and treatment and operational issues. The ward manager was very complimentary about her team. She felt that they were supportive of her and each other.
- The staff we spoke with were mostly positive about the ward. There were mixed views about the shift pattern and some staff felt that the 12 hour shifts were too long and interfered with ongoing training and development opportunities.
- There were fortnightly reflective practice forums that provided staff with the opportunity to think about the

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work they undertook with patients. There were also weekly nurse feedback meeting. These meetings gave staff the opportunity to share information and highlight key areas of work.

- There had been a staff away day in September 2015, which gave staff opportunity to give feedback about the ward.

Commitment to quality improvement and innovation

- The ward was working towards accreditation from the Quality Network for Eating Disorders. To achieve this, they had to demonstrate that they were meeting or working towards meeting national guidance and standards relating to eating disorders.
- Members of the multi-disciplinary team were members of the St George's University of London Eating Disorders Research Committee. There were quarterly meetings and the patients attended the meeting as experts by experience. Seven patients had attended on the most recent occasion.
- Researchers attended the ward community meetings from time to time to get the views of patients. Patients and the multi-disciplinary team had co-produced, "A Rough Guide to Avalon Ward" (2012) – generated by a working party of current staff and former service users and also a ward charter for therapeutic eating which was on display in the dining area.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff had received appropriate training to enable them to carry out the duties they were employed to perform. Significant numbers of staff had not completed required training in basic life support techniques, medicines management and fire safety awareness or had not updated this training when needed. This was a breach of regulation 18(2)(a)