Oak Tree Forest Limited

Ellern Mede Barnet

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location went down. We rated it as requires improvement because:

- The providers systems and processes to manage medicines safely were not always implemented and followed to keep patients safe.
- Staff did not always carry out and document patient observation checks as per hospital policy.
- When rapid tranquilisation was administered, staff did not always carry out physical health observations as per hospital policy. Staff did not always report incidents of rapid tranquilisation.
- The service had a high number of vacancies and a high use of agency staff. Agency staff did not always know the patient's care plans or receive training for the specific patient cohort which impacted upon the quality of care. At the time of inspection, the occupational therapist position and the clinical psychologist position were vacant. Due to these vacancies there were limited activities and therapeutic support offered to patients. The two consultant psychiatrists working at the hospital were both adult psychiatrists.
- Ward areas were small. Ward areas also had blind spots.
- The service was not always using information gathered through its governance systems to ensure that the quality of services were improved with appropriate mitigations taken with regards to risk. Whilst the service participated in clinical audit, they did not always use the findings to create action plans and make improvements. Team meetings did not always follow the set agenda points. This could lead to important information not being shared with the wider team. Discharge plans were not always documented within patient records. Induction checklists for agency staff did not document that agency staff were shown the ligature points on the ward.

However:

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service. Managers were approachable for patients, families and staff.
- Most staff felt respected, supported and valued. They said the hospital provided opportunities for development and career progression for most team members. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. Staff could raise any concerns without fear.
- Patients, carers and staff were able to provide feedback to the service. Managers used this feedback to make improvements.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patient's assessed needs, and were personalised, holistic and recovery-oriented. Staff involved patients and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. Staff assessed patient risk well.
- Staff ensured that had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.
- Permanent staff treated patients with compassion and kindness. Permanent staff understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The hospital and provider had a named safeguarding lead.
- The service managed patient safety incidents well. Staff recognised most incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Ellern Mede Barnet

Ellern Mede Barnet is a hospital run by Oak Tree Forest Limited. It provides eating disorder inpatient services for young people and adults aged 16 – 24 years. This hospital is for young people and adults of all genders. However, at the time of our inspection the patients were all female.

The hospital has 2 wards and an annex

- Rowan Ward has 4 beds. It is an intensive treatment ward for young people aged 16-18 years.
- Ash Ward has 7 beds. It is an intensive treatment ward for adults aged 18-24 years transitioning into adult services.
- The annex has 3 beds. This is a step down unit for those who are nearing discharge.

At the time of inspection, there were 13 people admitted to the service. Four young people were on Rowan Ward, 7 adults were on Ash Ward, and 2 adults were in the annex. Since the last inspection the hospital had moved their adult patients onto the larger ward as they were receiving more referrals for adults requiring beds.

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

We last inspected this service in February 2018. The service was rated as good overall, with a good rating for all domains.

What people who use the service say

We received mixed feedback from patients and carers.

Patients told us some staff were nice, caring and supportive. Some staff made an effort to speak with them and offer activities when they were on enhanced observations. However, they felt other staff did not have the skills and training to effectively support someone with an eating disorder. Some staff made unhelpful comments, and some staff were not aware of their individual care plans. Patients felt these concerns were mostly involving the agency staff on the ward.

Patients also reported the activities and therapeutic timetable on the ward could be improved.

Most carers told us they were involved in their child's care. They had regular meetings with a psychiatrist and were invited to attend a monthly carers meeting. Most families had been offered family therapy.

How we carried out this inspection

The team that inspected this service consisted of 2 CQC inspectors, a CQC inspection manager, a CQC pharmacist specialist, an expert by experience and a specialist advisor who had experience working within eating disorder services.

To get to the heart of patients' experiences of care and treatment, we always ask the following 5 questions:

- Is it safe?

Summary of this inspection

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

These questions therefore formed the framework for the areas we looked at during the inspection.

During the inspection visit, the inspection team:

- visited the service, observing the environment and how staff were caring for patients
- spoke with 4 patients who were using the service, received written feedback from 1 patient and reviewed feedback from the hospital's annual patient satisfaction survey.
- spoke with 5 carers of those using the service
- spoke with 18 members of staff from a range of roles, including, the hospital manager, ward manager, nurses, healthcare assistants, a dietitian, a consultant psychiatrist, a speciality doctor, an activity coordinator, the patient safety lead and the clinical governance manager
- attended a multidisciplinary team morning handover meeting
- reviewed 3 patient's care and treatment records including specific documentation related to the Mental Health Act
- reviewed how medication was managed and stored, including a review of medicine administration records
- reviewed 3 staff recruitment records
- reviewed information and documents relating to the operation and management of the service.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure all members of staff completing observations of patients document their observations correctly and vary the times they complete the checks. **Regulation 12(2)(b)**
- The service must follow the providers own medicines policy when recording and administering medicines. **Regulation 12(2)(g)**
- The service must carry out monitoring of post rapid tranquilisation administration in line with national guidance. Incidents of rapid tranquilisation must be reported in line with hospital policy. **Regulation 12(2)(g)**
- The service must continue in their attempts to recruit permanent members of staff to improve the quality and safety of care. **Regulation 18(1)**
- The service must consider the skill mix of staff on each shift to ensure restraints are carried out in line with the hospital's bespoke training. **Regulation 18(1)**
- The provider must ensure that all consultant psychiatrists complete mandatory training, including that which supports their work with adolescent patients. **Regulation 18(2)(a)**

Summary of this inspection

- The service must ensure it implements the model of care effectively and reviews the level of services available, including the activities and therapeutic support offered to all patients. **Regulation 12(2)(c)**
- The service must ensure it uses information gathered through its governance systems to ensure that the quality of services are improved with appropriate mitigations taken with regards to risk. **Regulation 17(1)(2)(a)(b)**

Action the service SHOULD take to improve:

- The service should ensure that all new agency staff are informed of the ligature points throughout the ward.
- The service should ensure they have adequately reduced the risks regarding blind spots throughout the ward and consider the use of convex mirrors where appropriate.
- The service should ensure agency staff have training on how to support patients with eating disorders.
- The hospital should ensure they record and implement action plans following audits, such as the hand washing audit and fire drills.
- The service should ensure the team meetings follow the set agenda to ensure all important topics are discussed.
- The service should ensure discharge planning is in place for all patients, including liaising with local authorities when appropriate.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Specialist eating disorder services

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

Are Specialist eating disorder services safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were clean, well equipped and well furnished. The hospital had many blind spots, which was mitigated by staffing levels and patient observations.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all ward areas and removed or reduced the risks they identified.

The hospital wards were small. All ward areas had several blind spots, meaning staff could not see patients at all times. Staff mitigated this risk with regular observations of patients. These observations were increased when a high level of risk was identified. There were no convex mirrors in place to help staff see patients in different parts of the ward.

The hospital carried out a ligature risk assessment of all ward areas. This assessment noted the ligature points throughout the ward and their mitigations. For example, staff ensured high ligature risk areas, such as the occupational therapy kitchen and garden, were kept locked. Staff supervised patients when they used these areas.

The staff we spoke with were aware of the ligature anchor points throughout the ward, as well as were the ligature cutters were located. The hospital had a heat map which identified high risk ligature areas in the environment.

Two bedroom doors had viewing panels to observe patients without needing to open the door. During the inspection all patients were noted to have their doors open, allowing easy observation.

The service accepted referrals for patients of all genders. At the time of inspection, all patients were female. All bedrooms were individual rooms with en-suites. Should a male be referred to the service, the 2 lounge area's on Ash Ward could be used as gender specific lounges.

Staff carried out routine checks of the environment twice per day to identify any matters that needed to be addressed. For example, staff noted when a carpet needed to be cleaned and when a sofa was torn.

The hospital had an alarm system, which allowed patients and staff to summon assistance if required. Wall alarms could be removed and were portable within a few meters. This meant staff did not carry personal alarms, unless they were accompanying a patient to the garden.

The service had closed-circuit television (CCTV) in all communal areas and corridor areas. CCTV was recorded and was used to review incidents on the wards. There were no cameras facing patient bedrooms or toilet areas. The main wards had posters explaining there was CCTV in operation and how the patients could go about requesting more information on this.

Fire safety arrangements were in place. The service had a fire risk assessment completed by an external company in August 2022. The service created an action plan following this assessment, and were part way through the improvements. There had been 2 fire drills within 2022, the last fire drill was carried out in November 2022. This fire drill document noted improvements to be made, such as more training for fire marshals and for staff to be reminded of certain aspects of the fire procedure. However, these points were not captured on the form as further action points and did not allocate a staff member to implement these improvements.

Maintenance, cleanliness and infection control

Ward areas were clean and well maintained. Some painting throughout the ward looked tired, however the hospital had already started painting part of the ward, with plans to redecorate throughout the hospital.

All ward areas shared a garden, which was well maintained. Adults, children and young people all used this space. Staff ensured all patients were supervised when in these areas.

Staff made sure cleaning records were up-to-date and the premises were clean. We saw housekeeping staff cleaning ward areas throughout the day.

Staff followed infection control principles including appropriate handwashing techniques, use of personal protective equipment and hand sanitiser was readily available. We observed all staff wearing face coverings in all parts of the service.

The hospital carried out a range of audits looking into cleanliness and infection control. On some occasions, senior staff followed up on areas of concern, for example, reminding staff false nails and nail polish should not be worn. However, the handwashing audit found ‘staff interviewed were unaware of correct hand washing procedures’ however ‘n/a’ was recorded for recommended actions.

Clinic room and equipment

Clinic rooms and the nasogastric feeding room were small. Nasogastric feeding could be administered in the clinic room, feeding room or patient bedroom.

A medicines inspector observed medication and a feed being carried out in a patient’s bedroom and noted appropriate infection control measures had been taken. Staff risk assessed where nasogastric feeding should take place. As the clinic

room and feeding room were small, nasogastric feeding under restraint could not always be carried out in these rooms. Staff recognised it was not always appropriate to carry out nasogastric feeds in bedrooms. We saw one patient did not want their nasogastric feed given in their bedroom and the hospital created a plan for this to be administered in another area of the hospital.

Clinic rooms were fully equipped with accessible equipment. Resuscitation equipment and emergency drugs were stored in reception. Resuscitation equipment was available to fit both children and adults. Staff carried out daily safety checks for the clinic room and emergency medicines.

Clinic rooms and equipment were clean. However, the clinic room on Ash Ward was noted to be cluttered.

Staff monitored the temperature of the clinic rooms and medicine fridges. Some gaps were noted in these records. However, these gaps had been identified in the weekly pharmacy audit and followed up as needed.

Ligature cutters were stored safely on each ward and staff knew where they were located.

Safe staffing

The service had a high number of vacancies and a high use of agency staff. With the use of agency staff, the service had enough nursing and medical staff to keep people safe from avoidable harm. However, agency staff did not always know the patients or receive basic training for the patient's specialist needs.

Nursing staff

With the use of bank and agency staff, the service had enough nursing and support staff to keep patients safe.

At the time of the inspection, the hospital had vacancies for 7 registered nurses and 44.9 healthcare assistants. The service had calculated the establishment for healthcare assistants to include permanent staff to cover enhanced observations, as they hoped to recruit to these roles. This accounted for around 21 of the healthcare assistant vacancies.

The service attempted to recruit into these positions all year round. The provider had recently employed a recruitment manager to lead on recruitment initiatives. The service held open days, as well as recruiting overseas for registered nurses. Three registered nurses and 22.4 healthcare assistants had been recruited and were in the process of their pre-employment checks.

The service used agency staff and their own bank staff to cover vacant regular shifts and when additional staff were needed. When the service used agency staff, managers requested staff familiar with the service.

In October 2022 agency nurses were used to fill 51.4% of shifts during that month. In the same time period, agency healthcare assistants were used to fill 84.7% of all shifts.

Managers were able to book agency staff in advance with block bookings. Managers made sure all agency staff had a full induction and understood the service before starting their shift. The service had an induction checklist for agency staff, which included information on topics such as fire procedures and location of emergency equipment. However, the hospital did not document that they were informing new agency staff of the ligature points on the ward. The agency staff we spoke with confirmed they attended an induction. Agency staff who worked regularly on the ward had access to the training offered by the hospital and in-house supervision. Since the inspection, the service had updated the agency induction checklist to include ligature anchor points.

Requires Improvement

Specialist eating disorder services

Safe staffing levels were achieved on most shifts. From June 2022 to November 2022, 93% of all shifts were filled.

The service had calculated the number of staff required for each shift using an internal tool. Managers adjusted staffing levels according to the needs of the patients. Additional staffing was booked if a patient required a higher level of observation or there were pre-booked activities, which affected staffing, such as longer escorted day leave.

Due to the high levels of observation and patient risk, the hospital had 2 registered nurses and 21 healthcare assistants to cover all ward areas during the day. At night the hospital had 2 registered nurses and 19 healthcare assistants.

A nurse was allocated to each of the main wards. The annex was staffed by healthcare assistants. The patients in the annex went to the main hospital to receive medication. Only patients who were low risk and nearing discharge were placed in the annex. Patients were not placed in the annex if they required nasogastric feeding.

Staff told us they would benefit from having an additional registered nurse to support the wards. The hospital had previously allocated 3 nurses on a day shift. The hospital had recently hired a ward manager, who's role included helping on shifts when additional nursing support was needed. However, staff told us this was not always possible due to their managerial role. Nurses told us they were not able to spend 1:1 time with patients due to the high number of nasogastric feeds on the wards. Patients told us there were not enough free staff available on each shift. They reported 1:1 sessions with their key workers were not happening.

Patients rarely had their escorted leave or activities cancelled. The service had enough staff on each shift to carry out any physical interventions safely.

The service had day and night medical cover and a doctor was available to attend the ward in an emergency. The hospital had 2 part time consultant psychiatrists for adults and a specialist registrar. The doctors worked a rota to provide cover out of hours. All medical staff were permanent members of staff. The service was able to access a child and adolescent consultant psychiatrist as needed from its nearby sister service.

The ward staff had access to out of hours support from a range of colleagues such as a specialty doctor, a consultant psychiatrist, a hospital manager, and a maintenance team member.

From May 2022 to October 2022, 15 staff members had left the hospital. The hospital had introduced some initiatives to try and retain staff, such as a bonus after 12 months working within the hospital. Some patients and carers told us there was a high turnover of staff. Patients told us newer staff often did not know them and their individual care plans.

Over the past 6 months the sickness rate for the hospital had been 6.8%, including long term sickness.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The hospital had an overall training completion score of 96.8%.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included topics such as basic and immediate life support training, safeguarding, infection control, fire safety and emergency first aid at work. The service also provided mandatory specialist training such as eating disorder awareness, feeding pump training and autism awareness training.

The provider had an e-learning platform, as well as a platform to live stream or record additional sessions. The e-learning platform contained all of the hospital's policies and lessons learnt bulletins. Managers were therefore able to see that staff had reviewed each policy and bulletin.

The hospital had a target of 90% for each training topic, however there were some training areas that fell below this. For example, the hospital's bespoke restraint intervention training was completed by 67.9% of staff. Whilst some long term agency staff had access to this training, other agency staff completed standard restraint training in line with their agency's guidance. This meant there was a risk patients were not being restrained in line with the hospital's bespoke policy.

Basic life support was completed by 75.8% of staff, food hygiene training was completed by 76.7% of staff and infection control training was completed by 78% of staff.

The lower levels of compliance were in part due to new members of staff who had not yet been on these face to face training courses. Managers planned to book these staff members on the next available course.

The provider had academic teaching sessions every 2 weeks. Staff from all hospitals within the provider were invited to attend these sessions via online videoconferencing facilities. A range of MDT members and external speakers had held sessions on topics such as updates on the latest guidance in eating disorder treatment and case presentation discussions.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were able to rota staff to attend training on specific dates.

Assessing and managing risk to patients and staff

Staff assessed patient risk well. However, staff did not always carry out and document observation checks as per hospital policy. Staff did not carry out physical health observations following rapid tranquilisation as per hospital policy.

Assessment and management of patient risk

During the inspection, we reviewed 3 patient's records. Staff completed risk assessments for each of these patients on admission. They updated and reviewed risk regularly, including after any incident.

The risk assessment included risks specific for this cohort of patients, for example, the risk of physical health concerns and re-feeding syndrome (a serious and potentially fatal condition that can occur during the process of reintroducing food after malnutrition or starvation).

Patient records showed evidence of patients being assessed by a dietitian within 2 days of admission in accordance with national guidance.

Patient's risk was discussed in handover meetings which were attended by all staff on shift. These risks were also discussed at the morning multidisciplinary team (MDT) handover meeting and at weekly ward rounds. Meetings included discussions on patient's progress and any changes to an individual's risk.

The service set the observation levels for patients according to the risk they presented. Some patients were on intermittent observations, which involved staff checking where the patient was at multiple times throughout the hour.

Other patients were on continuous observations which involved a member of staff being allocated to be with the patient at all times, for their safety or the safety of others. Three patients had 2 staff members with them at all times due to enhanced risk. Patient's observations were reviewed regularly with the patient, as well as weekly ward round meetings.

The hospital had an observation and engagement policy, which stated, 'It is important that the nurse carrying out the intermittent observations understands the importance of slightly 'varying' the frequency of the intermittent observations to reduce patient predictability in timings of observations'.

However, we found staff did not complete these checks at random times throughout the hour. The 15 minute observation sheets had been pre-printed with fixed times throughout the hour.

Staff were also completing 1 entry for the whole hour, as opposed to the more regular time of 15 minutes. It was therefore unclear if those patients were only checked once per hour. The same concern was seen on the 5 minute observation documents.

In addition to the individual patient observations, staff also carried out hourly checks on the ward environment.

Staff completed mandatory training in observations and engagement, 80.6% had completed this. However, a patient told us their allocated staff member did not always understand how to carry out the different observations. For example, when the patient was on 10 minute observations the staff members stayed with them at all times, effectively meaning they were on 1:1.

Some patients told us staff members were falling asleep on their enhanced observations on night shifts. The patients had informed the hospital seniors who investigated all claims. If staff were found to have been sleeping, managers moved staff to day shifts or limited the amount of extra hours staff worked.

Some patients told us they would have preferred female staff to complete their observations. Others said the managers did not swap staff members, even if the patient found the staff member on observations triggering. Managers reported all female patients would be supported by a female member of staff when carrying out their personal care.

Risk management plans were discussed and updated in multidisciplinary meetings. We saw evidence of risk being taken into consideration when creating care plans, such as, care plans around observation levels and leave outside of the hospital.

Staff applied blanket restrictions on patient's freedom only when justified. Blanket restrictions were proportionate to the needs of maintaining safety as well as a supportive environment for an eating disorder service. For example, the service did not permit patients to bring sharp objects onto the premises and toilets remained locked after mealtimes.

Use of restrictive interventions

In the 12 months between November 2021 and October 2022, the service reported 2164 incidents of restraint. Of those incidents, 1435 were planned restraint intervention to support nasogastric feeds and 709 were to prevent a patient causing intentional harm to themselves.

We saw evidence of individual care plans in place for those patients who received nasogastric feeds under restraint. For example, a patient requested their restraint to be carried out in an empty lounge area, and not their bedroom.

The hospital had a policy on the use of force and the use of restrictive interventions. This policy discussed the interventions they expected their staff to take before attempting to restrain a patient, such as de-escalation, distraction, and disengagement techniques.

Staff told us they restrained patients only when de-escalation techniques failed and when necessary to keep the patient or others safe. However, some patients told us they felt some staff would not spend much time trying to distract them, and use restraint early on. Some patients told us restraints were especially difficult for them as they did not like to be touched by other people due to their autism.

The service had recently updated their incident reporting system to include a separate feeding incident form due to the high numbers of these incidents. We reviewed incidents related to feeding restraints and saw information such as the staff involved, they type of restraint, and how long the patient was held in restraint.

The provider appointed a patient safety lead who led on reviewing incidents, safeguarding and restrictive practice. They also had oversight of the hospital's reducing restrictive practices programme, which included monitoring restraints and the use of enhanced observations. Incidents of restraint were discussed at the provider's quarterly clinical governance meetings.

The patient safety lead attended patient care meetings, with a specific focus on least restrictive intervention, asking questions such as, was the patient restriction level necessary and were there any alternative options they had not considered.

Staff received a bespoke evidence-based training programme looking at restrictive interventions for its patients called Ellern Mede Restrictive Interventions Support Training (EMRIST). This training showed staff how to correctly de-escalate and restrain patients when needed. The training also covered how to restrain a patient to carry out a nasogastric feed. At the time of inspection 67.9% of staff had completed this training.

All patients were encouraged to complete a Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) with staff. This was a set of questions which allowed patients to discuss any possible future restraints and their preferred management of these incidents. This allowed staff to support patients to develop their own personalised support plans, including triggers and preferred interventions. The hospital has a patient leaflet on restrictive practice, which encouraged patients to complete their PILRIMP to ensure staff's interventions were helpful to the patient.

From January 2022 to the time of inspection there had been 95 incidents reported as rapid tranquilisation. The data showed 42 of these occurred in April, and 41 of those were administered to 1 patient who was deemed high risk to herself and others. Overall, there were 15 patients who had been administered rapid tranquilisation in this timeframe. The hospitals data reported there had been 1 incident of rapid tranquilisation being administered in September 2022 and 1 incident in November 2022. However, whilst on inspection, we saw 3 incidents of rapid tranquilisation being administered in September and 3 incidents in November. The service was therefore not reporting all rapid tranquilisations as incidents.

The hospital had a rapid tranquilisation policy which included information on what should occur after an incident of rapid tranquilisation had occurred. This included the time scales for when physical health observations should be carried out in line with National Institute for Health and Care Excellence (NICE) guidance. The policy stated physical health observations should be carried out every 15 minutes for the first hour, followed by hourly observations until the fourth hour.

However, we found physical health observations were not always completed in line with the hospitals policy. On some occasions there had been no observations completed following incidents of rapid tranquilisation. Managers reported these patients were on 1:1 enhanced observations, therefore staff would have noted if the patient was deteriorating. Staff explained that full monitoring was not always practical, however staff did not document reasons why the observations did not take place. Records did not demonstrate that a minimum observation of respiration and level of consciousness was documented.

At the time of inspection 11 of the 13 patients were on enhanced observations, meaning a member of staff was with them at all times. These plans were reviewed, and staff provided examples of working with the patients to create a plan to reduce the level of restriction and observations.

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

The hospital carried out a range of audits related to restrictive practice. This included looking at learning and development, patient involvement and governance. The hospital identified learning such as, incorporating positive behavioural support plan training for staff completing PILRIMPs with patients.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. At the time of the inspection, 95% of staff had completed training in safeguarding adults and children.

Staff knew how to recognise adults and children at risk of harm and worked with other agencies to protect them.

The hospital manager was the safeguarding lead for the hospital site. The patient safety lead was the safeguarding lead for the provider. The safeguarding leads met monthly to discuss any safeguarding matters. Staff were aware they could approach these staff members with any safeguarding concerns.

The patient safety lead offered safeguarding supervision for staff once per month.

The hospital took action in response to safeguarding concerns to ensure patients remained safe.

The service had raised approximately 60 safeguarding concerns since January 2022. Three of these remained ‘live’ at the time of inspection and were being investigated.

Lessons learned from safeguarding concerns were shared with all staff via their online training portal and at monthly team meetings. For example, staff were reminded of the protocol around searching a particular patient’s packages following sharp items being sent to them.

One of the patients on the children’s ward had turned 18 years old and were classified as adults. The patient was due to be moved to a bed on the adult ward after our inspection. Whilst they remained on the children’s ward they were monitored by staff on a 1:1 basis.

Patients could receive visits from other young people such as siblings or friends. Visits needed to be supervised by an adult and took place in a room away from the wards.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records.

Patient notes were comprehensive, and all permanent staff had access to them. The hospital was able to grant long term agency staff access to their notes system, however other agency staff did not have access to this system.

Staff mostly used electronic records, but also had some of the records printed and stored in patients' folders.

All patients had their key documents, such as individual care plans, stored in a folder in their room.
This allowed all staff and patients easy access to these updated plans.

Physical health observations including weights were recorded in weekly MDT meetings minutes which were recorded electronically.

Records were stored securely. Electronic records could only be accessed by staff entering a username and confidential password. Hard copies of patient files were held in the nursing station or clinic room.

Medicines management

Although the provider had systems and processes in place to manage medicines safely, these were not always implemented and followed to keep people safe.

Medicines were stored safely and securely. However, we found on Ash ward, staff administering medicines did not always use the electronic medicines administration records (eMARs) to prepare and administer the medicines. We also saw when medicines had been administered the eMAR was not being completed and staff were recording administration on loose paper to complete later. This was not in line with the providers medicines policy. There was a risk that medicines may not be administered as directed by the prescriber.

Staff administered medicines to patients in a personalised way. There were varying degrees of support depending on what each person needed. However, we found that not all medicines administration was recorded in the eMARs. For example, 1 patient was administered rapid tranquilisation, but this had not been recorded in the eMARs in line with the providers policy. This was only recorded in the electronic daily notes. There was a risk that this could lead to repeated administration of medicines.

The provider had a detailed competency workbook and assessment for medicines which all staff responsible for administering medicines had completed.

Staff reviewed people's medicines regularly and provided specific advice to people and carers about their medicines. We saw documentation of regular multidisciplinary meetings where medicines were reviewed. Staff engaged with patients to ensure they were involved in their treatment plans.

Staff provided support to patients about their medicines, including family members, when patients were able to go for home leave.

A pharmacist reviewed medicines each week remotely, providing advice on administration and monitoring. There was a process for the pharmacist to raise interventions which required actioning by the clinical team. Advice from pharmacy was available remotely outside of the weekly visit and staff knew how to access this support. However, audits showed that interventions identified were not always implemented and therefore we could not be assured that improvements and learning was imbedded as a result of audits.

The service had systems to ensure staff knew about safety alerts and incidents, so people received their medicines safely. The pharmacist produced a report to the governance committee each month demonstrating incidents and trends in incidents. The provider had identified that they needed to work more on investigating individual incidents related to medicines and had planned for staff to receive additional training and supervision with the pharmacy team.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Relevant Mental Health Act forms were completed and reviewed regularly. Rapid tranquilisation had been used in the last 6 months. Staff were able to demonstrate an understanding of de-escalation and least restrictive practice when considering the use of when required medicines and rapid tranquilisation.

Staff reviewed the effects of each patient's medication on their physical health according to the manufacturer's instructions. We saw patients started on new medicines which required physical health monitoring prior to starting and regularly throughout treatment. We saw evidence that these initial health checks were completed.

Track record on safety

Reporting incidents and learning from when things go wrong

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

The service had recently updated their electronic reporting system. Staff had been trained how to use the updated system and knew what incidents to report.

The staff were encouraged to report all incidents. From 1 January 2022 to 15 November 2022 there had been a total of 2031 incidents reported. Of these incidents, 1353 were planned nasogastric feeding incidents. A further 629 incidents were reported as self-harm incidents. Many of the self-harming incidents related to 1 particular patient on the ward.

Managers reviewed and investigated the incidents that were reported. The service carried out monthly audits looking into themes from incidents. However, we noted some incidents of rapid tranquilisation were not always recorded as incidents, which affected the service's ability to investigate and notice themes. Feedback from investigations was shared with the wider team through lessons learnt bulletins.

Some patients told us they were hurt during a restraint, and were left with bruises. Managers were informed when a patient had been bruised during a restraint and investigated. They carried out body maps to capture the extent of the patient's injuries. In the last 12 months 5 patient injuries were reported during a nasogastric restraint. During this same time there was also 10 staff injuries during a nasogastric restraint. The investigation records we looked at did not indicate that these injuries had been caused by the use of improper restraint techniques.

Requires Improvement

Specialist eating disorder services

Managers debriefed and supported staff after any serious incident. Most staff we spoke with confirmed debriefs were held for both staff and patients. However, we did not always see debriefs recorded in patient notes following incidents.

The provider produced a monthly lessons learnt bulletins for their hospitals. Learning was therefore shared with all hospitals within the group. Learning from other hospitals within the provider included, reminding all staff of the legal framework around restraining an informal patient and nursing staff were reminded to communicate with their team members when taking over enhanced observations. As the patient safety lead was the lead for the provider, they were also able to share learning from incidents from other hospitals within the provider for learning and development.

There was evidence that changes had been made as a result of feedback from incidents. For example, the hospital implemented an electronic medication service following a review of medicine errors. The hospital was also planning to update their absent without leave policy following a recent incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, the service had apologised to a patient's carers for not updating them on their child's wellbeing prior to escorted leave.

Are Specialist eating disorder services effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patient's assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient on admission. We saw evidence in patient records of doctors completing comprehensive assessments which included reviewing the reasons for admission, a mental state examination and past medical history. We saw evidence of some patients having an assessment prior to their admission to ensure all risks and needs were known prior to the patient arriving on the ward.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff recorded patients' vital signs, which included regular weights.

All patients had a formal assessment of their nutritional status carried out by a qualified dietitian within 2 days of admission, in line with best practice.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We saw care plans related to a patient's mental health needs, their physical health needs, nasogastric feeding, and any dining support needs. Care plans included patient views.

Care plans were personalised, holistic and recovery orientated. Individual plans to treatment was clearly demonstrated in the Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP).

Requires Improvement

Specialist eating disorder services

Care and treatment plans were reviewed and updated following weekly multidisciplinary team (MDT) discussions. Patients attended MDT meetings every 2 weeks. A patient was able to provide written feedback to all meetings. Updates to plans were fed back and discussed with the patient if they did not attend the meeting.

Best practice in treatment and care

Patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. However, the service did not always use the findings from audits to make improvements. Due to the MDT vacancies at the time of inspection, there was a lack of group and therapeutic activities.

Staff provided care and treatment suitable for the patients in the service. However, some key MDT roles were vacant, which affected the range of treatment available.

Patients had access to some activities through the week. For example, art activities and access to games. The occupational therapist role was vacant. Patients told us there was a lack of structured activities through the week, especially on the weekend. The hospital had 2 activity coordinators, 1 of these worked every other weekend. Patients spoke highly of the activity coordinators, who supported them with individual activities. The activity coordinator who worked weekends had recently been on long term sick leave. The hospital had 3 main groups each week; a yoga session, a scrapbook session and an art group. The weekends consisted of 'patient led activities', meaning the patient would use the resources on the ward to decide what they would like to do on the day. Patients told us the activity timetable for half terms and school holidays was much better, as they included more structured activities, both within the hospital, and trips outside. Patients wondered why this level of activity was not available all of the time as only 2 patients in the hospital attended school.

The hospital had a family therapist. All families were offered evidence-based family interventions that addressed eating disorders and many families took park.

At the time of inspection, the hospital did not have a clinical psychologist. A clinical psychologist had been recruited and started following the inspection, in December 2022. The lack of a clinical psychologist for the hospital limited the psychological therapy offered to patients, both as individual sessions and group sessions.

The hospital had an equivalent of 1.4 psychology assistants who supported patients with individual sessions under the supervision of the lead psychologist, who had oversight of psychological therapies across the provider's London hospitals. Patients and carers commented they felt psychological therapy, including groups, was essential to their care and treatment.

The doctors considered National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines. Treatments for eating disorders were also based on national guidance which included managing emergencies in eating disorders (MEED). The hospital had 2 part time consultants, each working 3 days per week at the hospital. These consultants were adult psychiatrists. The patients at the hospital were all aged 16 and over. The consultants liaised with the medical director, who was a child and adolescent specialist, or child psychiatrists from other Ellern Mede hospital sites if there were any concerns for young people. The consultants also liaised with paediatric hospital specialists for any physical health concerns.

Requires Improvement

Specialist eating disorder services

The hospital had sought advice from the General Medical Council regarding consultant cover for adolescent patients. The provider confirmed their arrangements were in line with this advice, with both consultants required to complete mandatory training covering their work with this patient group. However, the mandatory training data we reviewed showed a 35% completion rate for one consultant. They had not completed training in the Mental Capacity Act, the Mental Health Act and prevent safeguarding training.

The provider previously had a dedicated Autistic Spectrum Disorder (ASD) lead nurse in response to increased referrals for patients with ASD or ASD traits. However, the staff member recently took another role within the provider. Some carers told us they felt more could have been done to support their child with their autism. Managers said they had plans to create an autism pathway team to support these patients.

Staff identified patients' physical health needs and recorded them in their care plans. Patients had their physical health assessed regularly throughout their admission. Physical health checks were comprehensive. Records showed all patients' physical health risks were assessed on admission by a doctor and included an assessment of the risk of refeeding syndrome and malnutrition.

Staff made sure patients had access to physical health care, including specialists as required.

Patient records showed appropriate referrals being made. For example, some patients had been referred for bone density scans and others had speech and language assessments.

The hospital had links with their local hospital emergency departments to ensure arrangements were in place if 1 of their patients needed to visit the hospital. This was to ensure better joint working and a better experience for patients and staff.

The hospital supported many patients with complex presentations, and the majority of their patients were admitted required nasogastric feeding. We saw evidence staff were reducing the level of support needed around nasogastric feeding during a patient's admission. For example, reducing the level of restraint needed during a nasogastric feed and reducing the need for sedation. Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The hospital had a dietitian and a dietitian assistant who reviewed all patient's treatment plans.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, providing patients opportunities for psychoeducation with outings for social snacks.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, the hospital used the Health of the Nation Outcome Scales (HoNOS) Children's Global Assessment Scale (CGAS) regularly to monitor patient's progress, symptoms and wellbeing.

The service monitored the effectiveness of care and treatment and used the findings to improve them. The service completed clinical audits in areas such as care and treatment, consent and capacity, and safeguarding.

On some occasions the services used this information to make improvements, for example, implementing an electronic medicines service following some medicine errors across the hospital. However, the service did not always use these results to make improvements. For example, when reviewing staff supervision and appraisal scores the recommended actions were 'this needs to be improved'. This was also seen in the infection control audit where staff wrote 'n/a' for recommended actions despite finding areas of improvement.

Requires Improvement

Specialist eating disorder services

Skilled staff to deliver care

The ward team had access to a range of specialists required to meet the needs of patients on the wards. However, some key roles were vacant. Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff. However, team meetings did not always cover the set agenda points.

Permanent staff had the skills and knowledge to meet the needs of people with an eating disorder. Many staff had extensive experience working in the eating disorders field. All nursing staff were specially trained to safely carry out nasogastric tube insertion and feeding. Healthcare assistants were trained to undertake electrocardiograms (ECG) and trained to take bloods.

Patients told us they felt agency staff did not have the specialist knowledge to support people with eating disorders. The hospital struggled to recruit permanent nurses and support workers. Patients told us there was a day prior to the inspection where there was 1 permanent member of staff on shift.

Managers gave each new member of staff a full induction to the service before they started work. Staff completed a 5 day induction, which included information on the policies and procedures at the hospital, as well as time to complete mandatory training sessions. The provider had a booklet to support healthcare assistants adjust to the new role, which included competency checks and space for reflection and supervision. New staff were allocated a buddy member of staff who supported them with any learning. Staff told us this was a comprehensive induction, with helpful sessions for the specific patient group, such as meal support with the hospital dietitians. Staff told us they had been shown where the ligature points were on the ward and was shown how to use the ligature cutters.

Whilst the service had a range of professionals as part of the multidisciplinary team there were some vacancies for key posts including an occupational therapist and clinical psychologist. This limited the professional expertise available to the service and the patients. The service tried to mitigate this by supporting other, often less experienced, staff to cover these areas of work. Occupational therapy was provided by activity co-ordinators and therapeutic support workers. The psychological therapeutic work was being carried out by psychology assistants. Both the clinical psychologist and occupational therapist roles had been recruited and the hospital confirmed these roles had been filled in December 2022.

Most staff said they received regular supervision and appraisals. In October 2022, 94% of staff had received supervision in line with the hospital's policy. All MDT staff members had received external supervision on a monthly basis.

At the time of inspection. 87% of staff had completed an appraisal in the last 12 months. Managers told us they had booked staff's appraisal meetings to ensure everyone had been seen before the end of the year.

Most staff described good opportunities to develop their professional skills. The hospital offered career progression for healthcare assistants, such as offering a senior healthcare assistant role, therapeutic support worker roles, apprenticeships and assistant psychology roles. However, other staff told us this progression was not available for registered nurses within the hospital.

Where staff were carrying out additional roles, such as training lead, the hospital was able to provide these staff with additional payments. There was also an educational fund available for staff members to access external training that would benefit their role and the service.

Team meetings occurred once a month and staff were encouraged to attend. Managers moved the time of the team meeting to the evening to allow staff from the day shift and night shift to attend. Some staff told us they did not think this time was suitable as they were required to stay later than their shift for the meeting.

Team meetings did have a fixed agenda; however, these agendas were not always being used in team meetings. Some meetings did not use any headings, instead, staff brought their concerns to be discussed. This could lead to important information and updates not being shared with staff, for example, incidents and the learning from these. Minutes were kept from these meetings and available for staff to review in the nursing office.

Managers recognised poor performance, they could identify the reasons and dealt with these. Managers understood the processes for managing poor performance and gave clear examples of the process they would follow to manage this. This included providing additional training and support, making amendments to shift patterns and disciplinary action via their human resources team when necessary.

Multi-disciplinary and interagency team work

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

Staff told us team members from different disciplines worked together as a team to benefit patient's care. They described close and supportive working relationships with other professionals.

Staff held weekly MDT ward rounds to discuss patient's care and treatment. All staff involved in the care of the patient was involved in this meeting to provide feedback and update care plans.

We attended the hospital daily MDT handover meeting. This involved a review of each patient. including discussing any risks or important updates from the previous day. Staff also updated the team if they would be meeting with a patient that day.

The hospital had effective working relationships with external teams and organisations. For example, the hospital invited community teams to Care Programme Approach (CPA) meetings to keep them updated on the latest treatment plan.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patient's rights to them.

Staff received and kept up to date with training on the Mental Health Act Code of Practice. At the time of inspection, 86.7% of staff had completed this training.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected the relevant legislation and the Mental Health Act Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

Patients had easy access to information about independent mental health advocacy. We saw posters on the wards and in reception areas displaying information on the advocacy services available. An advocate was due to visit the hospital once per week to meet with patients, however some patients said they had not seen the advocate on the ward for a few weeks.

Staff stored copies of patients' detention papers and associated records securely and staff could access them when needed. The relevant mental health act forms were in place to allow for medication administration in the person's best interest.

Records showed that where patients were detained under the Mental Health Act, staff explained their rights in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. However, a patient told us they had not had their rights read to them, but had been asked to sign the form saying they had. All patients had care plans related to their legal framework.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a second opinion appointed doctor (SOAD) when they needed to.

The Mental Health Act administrators made sure the service applied the Mental Health Act correctly by completing audits. Where gaps were identified, staff took action and stated who was responsible for each task.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to children under 16. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection 81.4% of staff had completed this training.

The Mental Capacity Act applies to people over the age of 16. For decisions about care and treatment in those under 16, staff referred to guidance on Gillick competence. This is a test established by case law to assist clinicians to determine whether a child of 16 years or under is competent to consent to medical examination or treatment. If a child is Gillick competent, they can give informed consent to an informal admission and treatment. All staff had completed training in Gillick competence.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Records showed capacity was assessed regularly by measuring a patient's ability to understand, retain and weigh up information before determining that they lacked capacity. The records specifically noted if a patient was able to weigh up information regarding food intake. All patients who were fed via a nasogastric feed were detained under the Mental Health Act.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. For example, all patients who had been assessed as lacking capacity had still been involved in developing recovery goals that were personal to them and their needs and interests.

Requires Improvement

Specialist eating disorder services

Are Specialist eating disorder services caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Permanent staff treated patients with compassion and kindness. Permanent staff understood the individual needs of patients and supported them to understand and manage their care, treatment or condition. However, some agency staff did not always know the patient's care plans and did not have the specialist training to support patients with an eating disorder.

Staff spoke with understanding, compassion and empathy when talking about the patients they were caring for. Staff were passionate about their work.

We observed positive interactions between patients and some staff members. However, we also saw some members of staff not engaging with the patients, especially those staff allocated to patient observations. Patients told us some staff made efforts to engage them with activities and conversations during their observations, whilst some other staff did not.

Patients reported the majority of permanent staff were kind, thoughtful and supportive. However, some of the agency staff were less supportive, making comments that were unhelpful and that some patients found unkind. Patients felt some agency staff did not have the specialist training needed to support people with an eating disorder.

Some patients told us they sometimes felt 'punished' for their behaviours, and that they needed to 'walk on eggshells' to avoid getting warnings. For example, needing to intake more calories if they were found to be over exercising.

Patients told us there were not enough staff members, and that they rarely got to meet with a staff member for a 1:1 key working session. They told us staff were all busy on patient observations and feeds. Patients told us there was a high use of agency staff, with a few patients mentioning a recent shift where there was 1 permanent nurse allocated, all other staff members were agency.

Permanent staff understood and respected the individual needs of each patient. This was seen in the Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) where patients were able to write in their own words the interventions that work well for them. However, patients felt agency staff did not know about their individual plans, so the care was inconsistent.

This concern was raised with the managers by the patients, and the hospital ensured all individual care plans were kept in each patient's bedroom for staff to have easy access to these plans. However, some patients said they were still needing to prompt staff to look at their plans.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke to felt confident in raising issues with managers. Staff had received additional training on boundaries within therapeutic relationships. At the time of inspection 97.7% of staff had completed boundaries for staff training.

Staff followed policy to keep patient's information confidential. Information was kept in nursing offices. Meetings to discuss a patient's care were held in offices and meeting rooms to ensure conversations could not be overheard.

Involvement in care

Staff involved patients and their families in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured patients had easy access to independent advocates, however advocates did not always visit the ward every week.

Involvement of patients

Most patients said they felt involved in aspects of their care planning. All patients had copies of their care plans.

Patients were invited to the multidisciplinary team (MDT) meeting every 2 weeks where the team discussed their progress and updated their care plans. Patients were also invited to give feedback to the meeting in writing each week. Most of the time staff told patients about the outcome of the meeting if they chose not to attend in person, however some patients said the changes to their care were not always communicated to them. The MDT discussion records were detailed, person-centred and looked at the holistic needs of each patient.

We saw clear evidence of patient's involvement in the PILRIMP care plan. These plans were written by the patients, in their own words. We also saw patient's own comments on their other care plans.

Activity staff were able to tailor the individual patient activities to their interests, for example, crochet. During community meetings, the activity coordinator asked for patients input on what crafts to purchase for activities and where they would like to go for their outings.

All patients felt able to provide feedback about their experience to the hospital. The service had feedback forms in communal areas, as well as a complaints poster. Patients had the hospital managers email address and were able to email any questions and queries directly to senior staff.

The service also collected feedback via an annual patient survey. The survey was last sent out in December 2021 and 6 patients completed the questionnaire. Overall, 63% of patients said they were satisfied with the overall care at the hospital. The next survey will be available to patients from December 2022.

Staff facilitated a community group meeting once a week for the hospital where young people could raise concerns about the environment or other issues affecting their stay. The meeting minutes made it clear which department was responsible for following up the concerns raised. However, this did not always have a date for the action to be completed by. Minutes from these meetings were displayed on ward notice boards.

Staff involved patients in decisions about the service, when appropriate. For example, patients had been involved in deciding what food would be cooked for their Christmas meal, and what items they would like in the new sensory room.

Staff made sure patients could access advocacy services. We saw posters on advocacy displayed on the wards. Advocates were due to visit the hospital on a weekly basis to speak to patients. The advocate gave the hospital a monthly report detailing how many sessions they conducted and the general themes of conversation. However, some

patients told us these visits were not happening weekly. We saw an advocate visited the hospital 4 times in October 2022 and 2 times in August 2022. The advocate was unable to attend the hospital in September 2022 due to illness. Another advocate was able to cover this hospital through online support and online meetings as needed during this time.

Involvement of families and carers

Staff informed and involved families and carers appropriately. However, some carers were concerned with the high turnover of staff and some key vacancies.

Staff supported, informed and involved families or carers. Records showed regular contact between the hospital and carers. For example, in family intervention sessions, video calls or telephone discussions.

Most carers told us they had been kept up to date with the most recent care plans, and would have regular discussions with the doctor on the ward. Some patients told us they did not consent for the hospital to share information with their carers, and the patients felt the hospital respected this decision.

Carers did not attend ward round meetings; however, they could provide feedback which was noted and discussed by staff. Carers would be updated with any changes to the care plans following this meeting. Carers were able to attend Care Programme Approach (CPA) meetings.

The hospital ran a carers group which all carers were invited to. One carer said they had only received the invite recently, and so had not been able to attend. For those carers that did attend the group, feedback was positive. Carers told us it was a space to share their thoughts and worries with others who were in similar positions.

Carers told us most staff were very supportive, and the care was tailored to their child's needs. Some carers said the ward was very responsive to their calls and emails, and the hospital manager was very approachable.

However, some carers were concerned about the lack of formal psychology and therapies being offered on the ward. Carers told us they felt an autism lead was needed for the service to provide input into their child's treatment plans. The hospital implemented mandatory training in autism awareness. At the time of inspection, 95.3% of staff had completed this training.

Most carers said they were concerned about the high turnover of staff. They felt this affected the consistency of care, as well as causing difficulties in sustaining a trusting relationship with the care team. Some carers said some staff lacked the training in how to support someone with an eating disorder. There was also not enough staff to allow their child to meet regularly with the nursing team.

One carer told us they felt communication could be improved, especially on information related to the hospital site, care expectations and possible outcomes. The hospital was in the process of updating their carers booklet to include more of this information. The hospital had also recently created 2 new animation videos. One of these was for new staff members, and the other was for new patients to show them what they can expect when they were admitted to the hospital.

Are Specialist eating disorder services responsive?

Requires Improvement

Specialist eating disorder services

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

The hospital had a clear admission criteria. The hospital worked well with some services providing aftercare, however discharge plans were not always documented within patient records.

The hospital provided beds on a spot purchase bases, this meant they received new referrals for patients from a range of geographical locations.

The service had set admission criteria. It provided a service for young people and adults who were aged between 16 and 24 years and had a diagnosis of an eating disorder with or without co-morbidities. Patients could be informal or detained under the Mental Health Act.

A patient's care and treatment was reviewed each week during the MDT meeting. Care Programme Approach (CPA) meetings were held every 12 weeks. Patients, carers and community teams were invited to these meetings.

Bed occupancy was high. Over the last 6 months the average bed occupancy for the hospital was 98%.

Managers reviewed the length of stay for patients on the ward. For patients who had been discharged the average length of stay had been 327.5 days. However, for their current group of patients their length of stay was 452.5 days. Managers reported this was due to the increase in acuity of their patients.

Managers monitored the number of patients whose discharge was delayed. The hospital had reported no delayed transfers of care for the 6 months period prior to our inspection.

The hospital had a lead social worker and a social work apprentice who worked with the patients to support discharge. However, records did not always include discharge discussions. Some patients and carers thought more could be done to support their discharge, for example, they felt staff could have had more contact with the local authority to support discharge planning.

Patients moved between ward areas, for example, when they turned 18, or were approaching discharge. These transitions ran smoothly as patients and staff knew each other across all ward areas. The hospital had an annex with 3 beds which were used as a step down unit to support patients who were approaching discharge. The annex had their own kitchen where patients were able to prepare their own meals.

All admissions were planned admissions. Staff did not move or discharge patients at night or very early in the morning. However, a patient told us they moved her to another room whilst she was at a hospital appointment without her knowledge.

Discharges followed a gradual approach made with the patient, their carers and the community teams. Patients would initially have escorted and unescorted leave. If this went well this would be extended to having time at home, followed by overnight leave. This plan would continue until the patient and staff felt confident the patient was ready to be discharged from the service. One patient was informal and was able to leave the hospital when requested.

Facilities that promote comfort, dignity and privacy

The facilities and furnishings of the hospital supported patient's treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe.

Each patient had their own bedroom, with an en-suite, which they could personalise.

Staff used a full range of rooms and equipment to support treatment and care. For example, an occupational therapy kitchen, an activity room, therapy rooms and lounges with TVs. There was a room outside in the garden that was planned to be a sensory room. Managers were consulting with patients for their ideas for the room before changes were made.

Patients were able to store valuables in their allocated lockers, as well as in nursing stations.

The service had a room where patients could meet with visitors in private. Where risks were low, patients were also able to meet with visitors outside of the hospital grounds.

Patients had access to their mobile phones, they could therefore make phone calls in private. The hospital had put safeguards on the WiFi to ensure patients were unable to access online content which could affect their recovery.

The service had an outside garden space that patients could access easily. All ward areas shared the garden space. Staff ensured this was used under supervision, especially if both children and adults were in the garden at the same time.

The hospital had access to a vehicle for excursions and driving patients to the hospital school.

Patient's engagement with the wider community

Children and young people had access to high quality education throughout their time on the ward. The ward offered a timetable of activities, however, this was affected by the vacant multidisciplinary team posts.

Children and young people were able to attend a school based at the provider's nearby hospital location. Staff drove the patients to this unit each weekday. The school was registered with Ofsted. Ofsted rated the school as 'outstanding' at their last inspection in February 2022. If patients were not well enough to attend school, a teacher was able to attend the hospital to meet with them.

During the half term weeks, the hospital had arranged a number of outings, such as, pumpkin picking, laser tag and bowling.

Staff helped patients to stay in contact with families and carers. Patients were able to access their phones and laptops to support communication. Many families were not from London. The hospital supported carers to attend meetings via video conferencing facilities. The hospital had recently updated their visitor system. All visitors were required to book a slot for visits in advance.

Requires Improvement

Specialist eating disorder services

Meeting the needs of all people who use the service

The service met the needs of patients – including those with a protected characteristic. However, some carers told us more support was needed for their child with autism. Staff helped patients with communication, cultural and spiritual support.

The service was accessible to patients with disabilities. There was a lift available and an evacuation chair for the stairs in an emergency.

The service had access to interpreters when required. Written information could also be translated if a patient's first language was not English, but this was not required for the current inpatient group.

The activities and equipment provided were based on the interests and preferences of the patients, for example currently crochet.

Staff ensured patients had access to appropriate spiritual support. The service had a multi-faith room. The service had in the past supported patients to attend places of worship should they want this.

Staff received training in equality, diversity and inclusion. At the time of inspection 96% of staff had completed this. The hospital had introduced mandatory training in supporting LGBTQ+ patients, and this had been completed by 98% of staff. Staff told us how they had supported patients with different genders, using preferred pronouns

However, some carers told us they felt more could have been done to support their child's specific needs related to their autism.

Patients were also able to address their specific needs in their Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP).

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service. However, lessons learnt were not always shared in team meetings.

The hospital had received 7 formal complaints since January 2022. Two of these complaints remained open investigations. Of the 5 complaints that had been closed, 4 were partially upheld and 1 was not upheld.

Patients and carers knew how to complain or raise concerns. There were leaflets displayed in ward areas as well as the waiting room with information on how to complain or provide feedback.

Staff understood the policy on complaints and knew how to handle them. The hospital policy stated the service had 25 days to formally respond to a complaint. All complaints had been acknowledged within a day of receiving the concern. All closed complaints, apart from 1, had been investigated within the target time frames. One complaint response had been delayed by the investigation requiring further time. This complaint response was sent 5 days later.

Requires Improvement

Specialist eating disorder services

The service kept a log of all complaints with their outcomes, this supported them in monitoring their adherence to the time scales. Managers investigated these complaints and identified themes. Managers would speak to patients or carers directly if they complained to try to resolve the issue. However, a carer told us they had made a complaint, but did not feel the service listened as they had not made any amendments to their child's care and treatment.

Managers shared feedback from complaints with staff, including raising individual concerns in a staff member's supervision session. For example, reminding staff members to remain vigilant when they observed a patient. However, team meetings did not document that learning and outcomes from complaints were regularly shared with the nursing team.

Patients were able to raise requests, feedback and informal complaints in the weekly hospital community meetings. The meeting minutes showed changes were made as a result of patient feedback, such as choosing different outings, providing TV streaming access, and the dietitian implementing social snacks. However, some issues raised, specifically related to maintenance concerns, took a few weeks to be resolved. For example, patients had complained about the ward being too cold in 3 weeks of meetings before being resolved and a patient had requested a bin in her room for 4 weeks before this had been documented as ordered.

Patients could also raise concerns with the patient representative. This was a patient who was nearing discharge. The patient representative would speak with patients and feed any concerns back to senior staff members. They reported some patients felt more comfortable raising concerns through another patient they knew.

The service kept a range of compliments that they had received. The service used compliments to learn, celebrate success and improve the quality of care.

Are Specialist eating disorder services well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

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

Leaders had experience to manage the service safely. Key senior staff members such as the medical director and clinical operations director had been in their roles for a number of years. The hospital manager had been in post since May 2022; however, they had previously been a hospital manager at another Ellern Mede hospital.

Leaders had a good understanding of the service they managed. They were aware of the key challenges and risks and were open in sharing them. For example, the managers had a number of recruitment days to recruit nurses and support workers. They had also recruited into key multidisciplinary vacancies to support patient's care and treatment, who were due to start in December 2022. The hospital manager met with patients regularly, and knew their treatment plans and needs.

Staff described the hospital manager as visible and approachable. They told us they could get support from them when they needed it. The hospital manager attended multidisciplinary team meetings as well as handover meetings to support staff as needed.

Vision and strategy

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

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

The hospital's goal was to help the patient develop trust in the team and use the hospital as a resource to gain the strength, esteem and confidence to challenge their illness.

The service also had a set of care values, which included, kind and caring, honesty and integrity, respect and dignity, professionalism, team player and robust.

The hospital had mandatory training on the hospital values, and 96% of staff had completed this. Values were also shared with staff on their induction to the service.

Staff spoke with compassion and kindness about the care they provided to their patients. They spoke with pride about the recovery stories they had seen. Staff spoke about the importance of team working to provide the best outcomes for their patients.

Most patients reported the permanent staff were kind, caring and treated them with respect. However, they felt some of the agency staff did not have the training needed to support them in a kind and caring way.

Culture

Most staff felt respected, supported and valued. They said the hospital provided opportunities for development and career progression for most team members. They could raise any concerns without fear.

Most staff felt positive and proud about working for this service and the positive outcomes they had seen for the patients they cared for.

Most staff described good morale within the team and were positive about their colleagues. Most staff spoke highly of the management team and reported a good culture within the hospital.

Most staff described the registered manager as approachable and supportive and felt valued by the team and managers. Managers responded to staff's request for the break room and ordered a coffee machine and a sandwich press.

Development opportunities were available for staff. Staff who were healthcare assistants had been supported into roles such as senior healthcare assistants, therapeutic support workers and an apprentice social worker. However, some registered nurses felt there was a lack of opportunities for career progression for them.

The service had a whistleblowing policy and had a Freedom to Speak Up Guardian. Staff reported they were aware of these procedures. There were posters in staff areas and reception informing them of the key information.

Managers dealt with poor staff performance when needed. Managers gave clear examples of the process they would follow to manage poor performance. This included creating action plans, providing additional training and support, and disciplinary action when necessary.

Staff appraisals included conversations about career development and how they could be supported. The service offered an education fund available for all permanent staff, who have been employed for over 1 year, to support continuing professional development.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service offered a range of support and guidance, including being able to book individual counselling sessions.

The provider recognised staff success within the service, for example, through the monthly staff 'extra mile' awards. For these awards, staff nominated a member of staff for their exceptional care and support.

Governance

Our findings from the other key questions demonstrated that whilst governance processes were in place, improvements were needed. The hospital was not able to fully implement its therapeutic model due to staff vacancies. Arrangements to ensure appropriate CAMHS consultant cover were not clear. How the wards ensured an appropriate skill mix for each shift to implement bespoke restraint training was also unclear, as was how the hospital ensured that an appropriate space outside of the patient's bedroom was always available for nasogastric feeding whilst being restrained. Team meetings did not always follow the pre-set agenda. The hospital did not always use the findings from audits to make improvements.

There was a clear framework of what must be discussed at a management level in meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. However, this same level of assurance was not seen for ward team meetings.

The service held quality safety and strategy meetings every 3 months. These meetings were attended by senior staff members across all of the provider's locations and had a structured agenda. The meetings had updates from subcommittees, such as the audit committee and governance committee. They also reviewed risks, safeguarding and incidents that had occurred and affected the provider as a whole.

The hospital also had monthly quality meetings where they discussed performance, risks and updates specifically related to the hospital site. These monthly meetings would discuss the local concerns that needed to be raised with the provider as a whole at their larger quarterly quality safety and strategy meetings.

The service had robust recruitment and employment processes in place. We reviewed 3 staff human resources files whilst on site. These files were well-organised and records contained appropriate information regarding the recruitment process, references, disclosure and barring service checks and where appropriate confirmation of professional registration.

Staff participated in local audits. From January 2022 to November 2022 the service carried out audits in 20 areas. Examples of audits included infection prevention and control audits, prescription chart audits and environmental audits. However, the service did not always use results from audits to make improvements, for example, they had not documented actions after noting staff were not aware of the correct handwashing techniques.

The service had external auditors assess their health and safety and conduct a fire risk assessment. Following these reviews, the hospital compiled a list of the actions required, who was responsible for the action, and any updates. Some of these actions had been completed, such as, ensuring a door was fixed so it closed properly. Other work was ongoing, such as, fitting a fire alarm in Ash Ward's nursing station.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. For example, staff were reminded of the of the legal framework surrounding informal patients and restraint. Staff were also signposted to training when a need was identified.

Management of risk, issues and performance

The service had effective risk management systems in place.

Staff maintained and had access to the risk register. The register was updated at the governance meetings and staff at all levels could escalate concerns when required.

The hospital created risk posters each month which highlighted the key risk areas for the hospital in an easy to read format.

Staff concerns matched those on the risk register, for example, staff vacancies and the risks associated with having a high volume of new starters.

The hospital worked with a high number of agency staff. Patients told us these staff members were often not specifically trained in eating disorders. The managers were aware of these concerns and had been attempting to recruit new permanent staff throughout the year.

The service had a business continuity plan which covered possible incidents and recovery plans. For example, it showed the procedure if the service had a power cut.

Information management

The service had systems and the technology in place to carry out their roles effectively.

The service used systems to collect data from wards that were not over-burdensome for frontline staff.

Data was collected and used to produce regular reports for the senior management team which provided oversight of the service.

The electronic patient records system was effective for documenting patient's needs and care plans. The provider had recently updated their incident management system to align to the service needs.

Information governance systems included confidentiality of patient's records. Training in data protection regulations were included in the hospital's mandatory training. At the time of inspection 78% of staff had completed this training.

Managers had access to information to support them with their management role. This included information on the performance of the service, staffing and the care they provided.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, some staff told us the WiFi on the wards was not working to allow them to use laptops to dispense medication.

Staff made notifications to external bodies as needed, including the Care Quality Commission. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about possible abuse of their patients. The hospital had a notifiable incidents email address where staff could email the governance team with any concerns to ensure notifications were sent in a timely manner.

Engagement

Patient, carers and staff were able to provide feedback to the service. Managers used this feedback to make improvements.

Staff and patients had access to up to date information about the work of the provider and the services they used. Staff were kept up to date through team meeting and emails. Patients were kept up to date through community meetings. Due to the small size of the hospital managers were able to meet with staff and patients regularly.

Patients and carers had opportunities to give feedback on the service they received. Patients completed a yearly survey on topics related to their experience of care at the hospital. Patients could also provide feedback via the feedback forms in reception and community meetings. Carers were able to provide feedback at any time by calling the ward as well as during their meetings with staff and the monthly carer meetings.

Patients were consulted on matters such as ideas for a sensory room, activity suggestions and Christmas menus in the weekly community meetings.

Managers and staff had access to the feedback from patients, carers and staff and they used it to make improvements. For example, fixing any maintenance concerns and reviewing care plans following complaints.

Patients and staff could meet with members of the hospital's senior leadership team to give feedback. The management team worked closely with the patients and staff in an open and approachable manner.

Learning, continuous improvement and innovation

Staff engaged effectively in quality and service improvement activities.

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

Innovations continued to take place in the service. The service had continued to use the Patient Inclusion in Least Restrictive Intervention Management Plan (PILRIMP) to support patients be involved in their care and treatment. This framework specifically looked at ensuring least restrictive practice was used for all patients.

The service had also created Ellern Mede Restrictive Interventions Support Training (EMRIST), a bespoke training package for supporting and restraining patients, with a specific emphasis on safe practice when planning nasogastric feeding. This training comprised of workshops, presentations and workbooks to consolidate the learning.

Requires Improvement

Specialist eating disorder services

The hospital had been participating in regular QNIC reviews. This was a quality standard programme of peer reviewers measuring the service against the standards. However, the hospital had not signed up for accreditation through this network.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure all members of staff completing observations of patients document their observations correctly and vary the times they complete the checks. Regulation 12(2)(b) • The service must follow the providers own medicines policy when recording and administering medicines. Regulation 12(2)(g) • The service must carry out monitoring of post rapid tranquilisation administration in line with national guidance. Incidents of rapid tranquilisation must be reported in line with hospital policy. Regulation 12(2)(g) • The service must ensure it implements their model of care effectively, including the activities and therapeutic support offered to all patients. Regulation 12(2)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure it uses information gathered through its governance systems to ensure that the quality of services are improved with appropriate mitigations taken with regards to risk. Regulation 17(1)(2)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

- The service must continue in their attempts to recruit permanent members of staff. Regulation 18(1)
- The service must consider the skill mix of their staff to ensure restraints are carried out in line with the hospital's bespoke training. Regulation 18(1)
- The provider must ensure that all consultant psychiatrists complete mandatory training, including that which supports their work with adolescent patients. Regulation 18(2)(a)