RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QED
QUALITY NETWORK FOR EATING DISORDERS

QED INPATIENT

# ANNUAL REPORT

2022 - 2023

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# FOREWORD

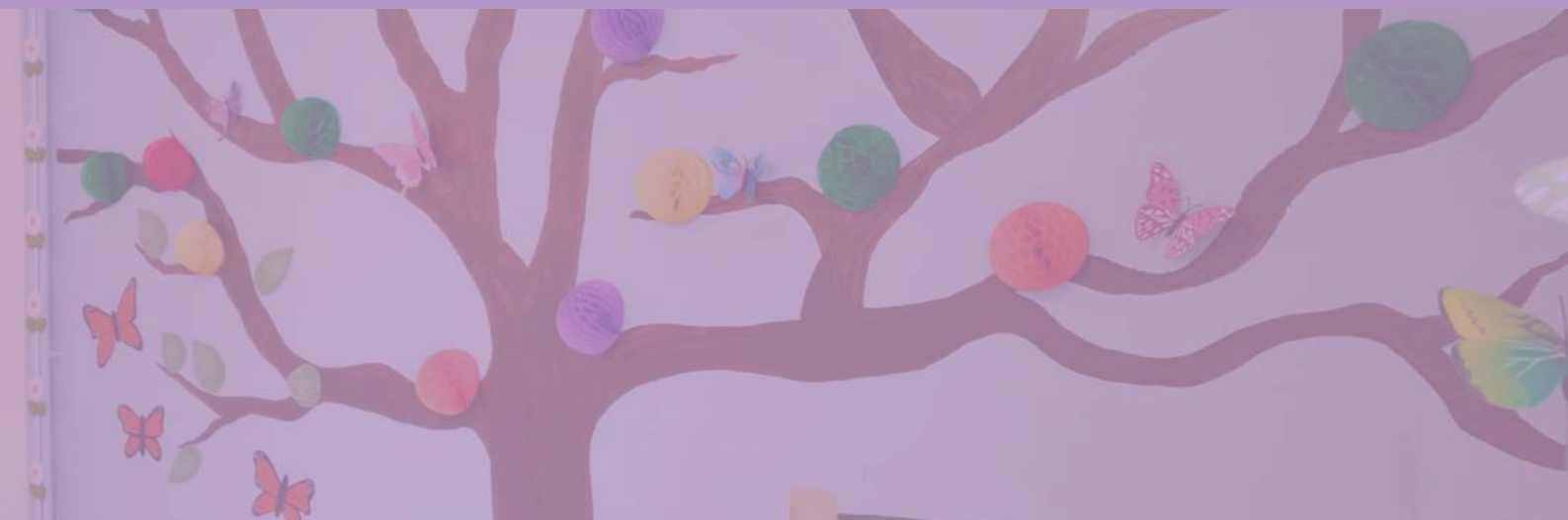
*I am the mother of two daughters who had an eating disorder and a carer representative on QED and am often part of the QED reviewing team. I am therefore delighted to have been asked to write the foreword for the 2021 – 2023 inpatient standards which is an area I feel passionately about. Services are still under pressure and working in very challenging situations post the pandemic, so it is encouraging to see considerable areas of achievements and good practice set out in this report and is testament to all the hard work that the Services do.*

*It also needs to be acknowledged that this report has taken a significant amount of time and work for the QED team in addition to their day-to-day commitments. The report is very comprehensive in the way it has been presented making it easy to read and understand.*

*The report highlights overall a range of improvements including carer involvement. Two areas that may need further attention regarding the carer are those surrounding discharge and QI projects. In terms of discharge carer involvement (with patients' consent) is of paramount importance. The carer needs to fully understand what is required of them when the patient comes home. A collaborative approach makes for more harmonious relationships within the family. As it relates to QI projects, they provide a systematic approach to tackling problems and implementing changes and the carer should always be part of that process.*

*The report highlights how much has been achieved in the two years that this report refers to and I hope that for those who read it they will be proud of the many achievements that they have made in circumstances far from ideal.*

***Veronica Kamerling***
***Carer Representative, QED***



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# INTRODUCTION

**Who we are**

The Quality Network for Eating Disorders (QED) works with inpatient and community services to ensure and enhance the quality of care provided to individuals with eating disorders and their carers. Established as an independent network in 2012, QED is part of a larger initiative by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI), which includes approximately 30 quality networks, accreditation projects, and audit programmes.

**What we do**

Through a comprehensive process of review, we identify and acknowledge high standards of organisation and patient care and support other services to achieve these. We support and engage inpatient units and community services in a process of quality improvement through peer-led reviews against a set of specialist standards for eating disorders. The process is supportive and promotes sharing of best practice between units. Involving service users and carers in QED is a priority, and people with first-hand experience of using eating disorders services are encouraged to get involved in all stages of the review process.

The network is supported by two crucial groups: the Advisory Group who is a dedicated team to provide guidance for the network's continued development and promotion. They actively contribute to shaping national recommendations for inpatient and community services. The Accreditation Committee also plays a pivotal role in informing key accreditation decisions and upholding consistency of the process. Comprising professionals and experts by experience , both groups represent areas of expertise within the field of eating disorder services.

**Annual review cycle**

The review process has 2 phases:

- Completion of a self-review questionnaire
- External peer-review


For teams that undergo accreditation, their status remains valid for three years from the date of their initial presentation to the Accreditation Committee. During this period, the team's adherence to the QED standards is continuously assessed and upheld.

# REPORT INFORMATION

The QED Inpatient report provides an overview of the adherence to the QED 3rd Edition Inpatient Standards from twenty-seven services across England. Overall, 11 services took part in a review in the 2021 - 2022 cycle and 16 took part in the 2022 - 2023 cycle. The team collated the data from the twenty-seven accreditation reviews and carried out quantitative analysis to ascertain the overall compliance to the QED 3rd Edition Inpatient Standards.

**What to expect in this report:**

This national report contains the aggregated results of the reviews undertaken by 27 adult inpatient eating disorder services during the 2021 - 2022 cycle and the 2022 - 2023 cycle. It examines contextual data obtained from all services, including average number of beds, average length of stay, mixed or single sex service, as well as WTE staffing numbers.

QED inpatient member services' local reports provide the team with a summary of the number of standard criteria 'met', 'not met', or 'N/A', which then yields an average score for each individual standard. These averages enabled us to obtain a measure of the team's overall performance for each section of the service standards. The overall compliance for standard domains can be found on page 7.

The main body of the report compares data (average met scores) from the earlier cycle to the latter cycle, highlighting key achievements and areas for improvement across services from each standard domain of the QED Standards. Recommendations, best practice examples and feedback from patients, carers or staff members are also provided for each standard domain.

Finally, a full summary detailing the average scores for each criterion for all participating teams is included (see Appendix 2).

**How to use the findings:**

Within each section, the QED team have highlighted best practice seen on peer review days to make recommendations on how to meet the most commonly 'unmet' standards. Clinicians working in eating disorder services can view these and consider implementation within their own units.

**Service locations:**

Nearly all inpatient eating disorder services within the UK are members of the QED network and therefore cover a wide spread of the UK.

# QED 3RD EDITION INPATIENT STANDARDS

The QED assesses eating disorder services according to a set of standards. The network undergoes a standards revision process every two years. These standards are drawn from a variety of authoritative sources and incorporate feedback from patient and carer representatives, as well as experts from relevant professions.

The standards are used to generate a series of data collection tools for use in the self and peer review processes. Participating teams rate themselves against the standards during their self-review. This model aims to facilitate incremental improvements in service quality.

The standards are split into eight subsections:

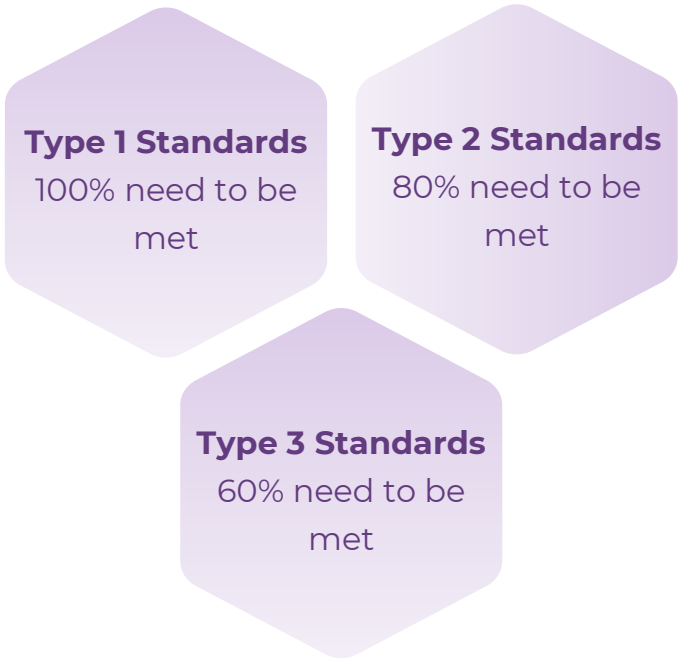
- Access and Admission
- Environment and Facilities
- Staffing and Training
- Care and Treatment
- Information, Consent and Confidentiality
- Rights and Safeguarding
- Discharge
- Clinical Governance

Standards are categorised as a type 1, 2 or 3.

**Type 1** standards relate to patient safety, rights or dignity. Failure to meet these standards would represent a significant threat to patients and/or would break the law. Accredited services need to meet 100% of these.

**Type 2** standards are standards we expect services to meet. Accredited services need to meet at least 80% of these.

**Type 3** standards are criteria that an exceptional service should meet or are standards that are not the direct responsibility of the team. Accredited services must meet at least 60% of these.



# CONTEXTUAL DATA

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## 2021-2022

**13.45**

Average number of beds, ranging from 6 to 27

115.54

Average length of stay (days), ranging from 75 to 244 days

**100%**

of services reported as mixed sex services

## 2022-2023

13.19

Average number of beds, ranging from 5 to 23

**129.2**

Average length of stay (days), ranging from 40 to 232 days

94%

of services reported as mixed sex services

# CONTEXTUAL DATA CONTINUED

All units engaging in a QED review were also asked to provide a breakdown of their WTE staffing numbers to gain a national picture of any staffing shortages services may be facing.

## Average WTE of service occupations in relation to numbers of beds*

| Staffing Type | 2021-2022 | 2022-2023 |
|---|---|---|
| Consultant Psychiatrist | 0.1 | 0.09 |
| Non-consultant Psychiatrist | 0.03 | 0.1 |
| Dietician | 0.07 | 0.19 |
| Psychologist | 0.34 | 0.16 |
| Occupational Therapist | 0.11 | 0.12 |
| Ward Manager | 0.09 | 0.09 |
| Registered Nurses | 0.7 | 0.72 |
| Nursing Assistants | 0.9 | 0.95 |
| Social Worker | 0.01 | 0.02 |
| Family Therapist | 0.04 | 0.05 |
| Administrator | 0.12 | 0.12 |

*Within each service, WTE for each occupation was divided by the number of beds. Figures show the average WTE per bed. These results were collated from 16 inpatient teams for the 2022-2023 cycle and 11 teams from the 2021-2022 cycle.

# OVERALL COMPLIANCE WITH STANDARDS

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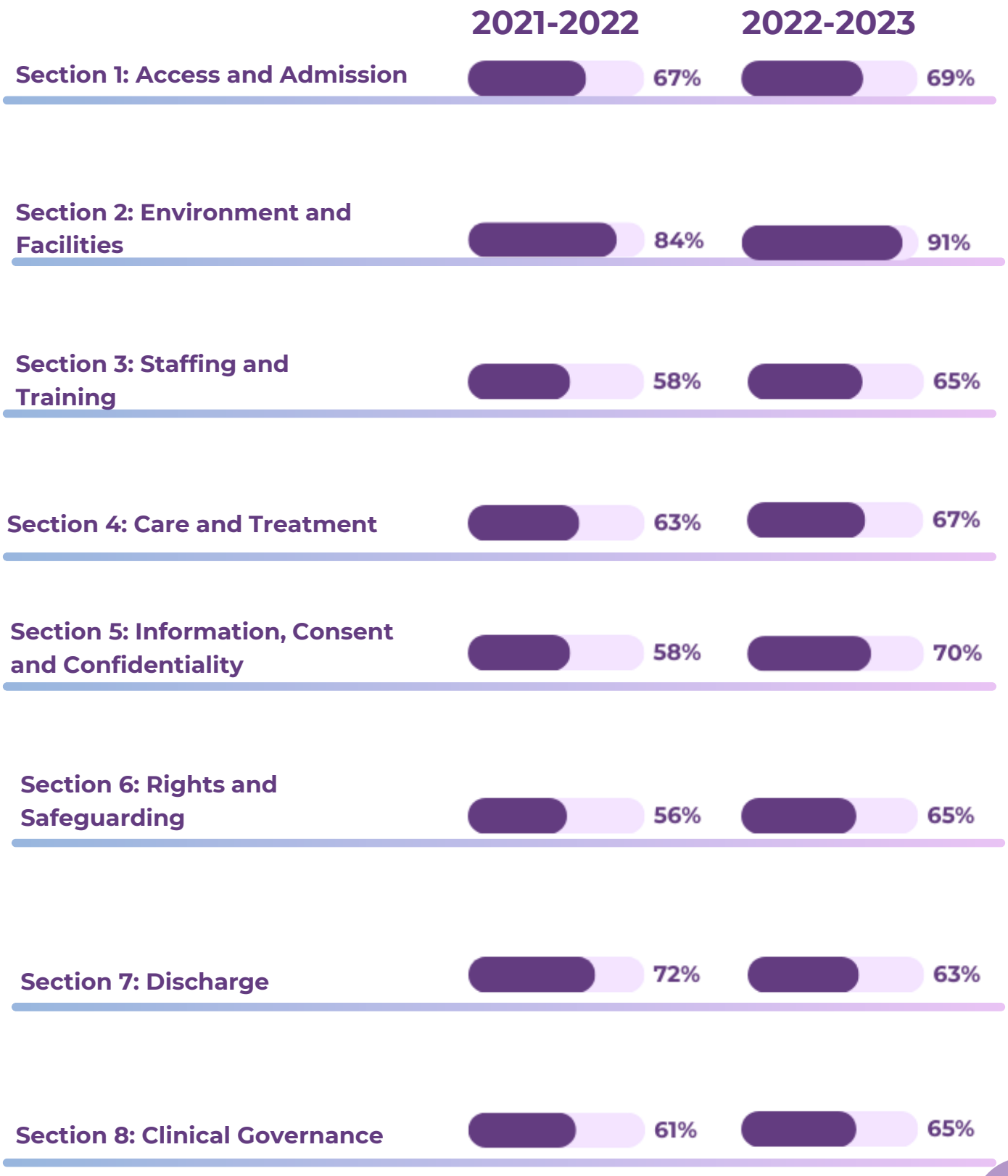
All services were assessed on their compliance with the Third edition of the QED inpatient standards. Below is the average total adherence to each of the subsections of these standards (counting "Partly Met", and "Unmet" as not adherent, and "met" as adherent).




*2021 - 2022 data based on 11 inpatient units
*2022 - 2023 data based on 16 inpatient units

# SECTION ONE: ACCESS AND ADMISSION

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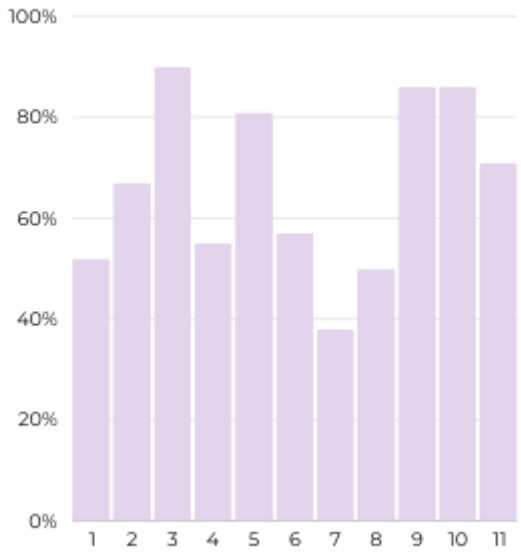
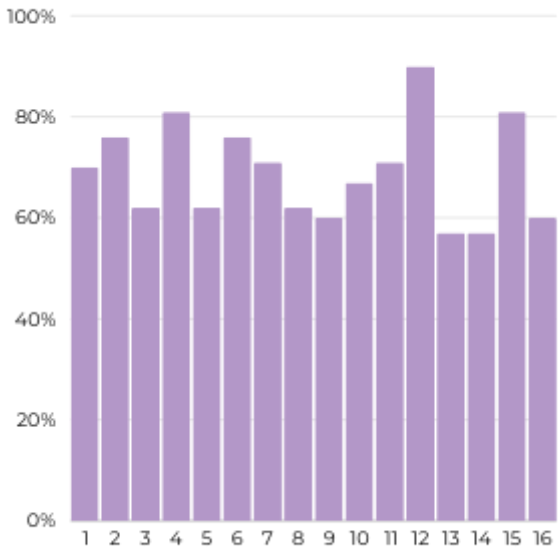
**Total Met standards (%)**

## 2021-2022




## 2022-2023




## Key Achievements

- Since the 2021-2022 cycle, there has been an average increase of **17%** of wards that contact the referrer immediately to inform, ascertain the patient's level of risk, and agree a plan with them as soon as is practically possible (1.2.7).
- In the recent cycle, **94%** of teams reported that a representative from the community eating disorder team is invited to attend the first review, whereas only **64%** were reportedly inviting them in the 2021-2022 cycle (1.2.9).
- In the recent cycle, **100%** of teams reported that as part of the initial assessment, assessment is made of the risk factors for refeeding syndrome, appropriate action is taken if indicated, and this is recorded, whereas **91%** were meeting this standard in the earlier cycle (1.2.4).

## Areas of Development

- **36%** in the earlier cycle and 19% in the latter cycle did not invite patients and their families/carers to the ward or unit prior to admission to familiarise themselves with the environment (1.3.1).
- **31%** of services offer individual time with carers within 48 hours of the patient's admission to discuss concerns, family history or their own needs (1.3.4).
- **19%** of services reported that they signpost to nearby facilities for their family/carers to stay overnight where appropriate, whereas **36%** were meeting this standard in the 2021-2022 cycle (1.3.5).

# SECTION ONE: ACCESS AND ADMISSION

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 1.3.1**  | Patients and their families/carers are invited to visit the ward/unit prior to admission. Guidance: This may be achieved virtually, e.g., through a video tour. | If an in-person visit isn't possible, there will be alternative ways for a patient and their carer to familiarise themselves with a ward. Some units have developed a video tour or a video walkthrough of the facility. Comprehensive and detailed information leaflets can also be sent to the patient and their family/carer in this occasion, which includes detailed images and information. Providing patients and carers with resources such as in-depth floor plans, photos and descriptions can be useful to reduce anxiety, particularly as patients are able to visualise the environment, they will be staying in. Including quotes from previous patients within this information is also helpful to support people to know what to expect from the admission. |
| **Standard 1.3.4**  | Carers are offered individual time with staff members within 48 hours of the patient's admission to discuss concerns, family history and their own needs. | Services could assign a staff member (such as a nurse or care coordinator) as a 'carers champion' to meet with, or speak to, family members or carers shortly after admission. This should occur within the first 48 hours of their loved one's admission and can be in-person or virtual.<br><br>Some teams have added this into their admission checklist to ensure that it is a formalised part of the process. |

## Example of Good Practice

- When visiting the ward, the review team were given personal alarms and noticed alarms on the walls. It is very important for safety that everyone has access to alarms.

> ***"There was a video tour of the unit on the service's website which helped me feel more comfortable as I could visualise the environment my loved one was going into"***
>
> ***- Carer***

# SECTION TWO: ENVIRONMENT AND FACILITIES

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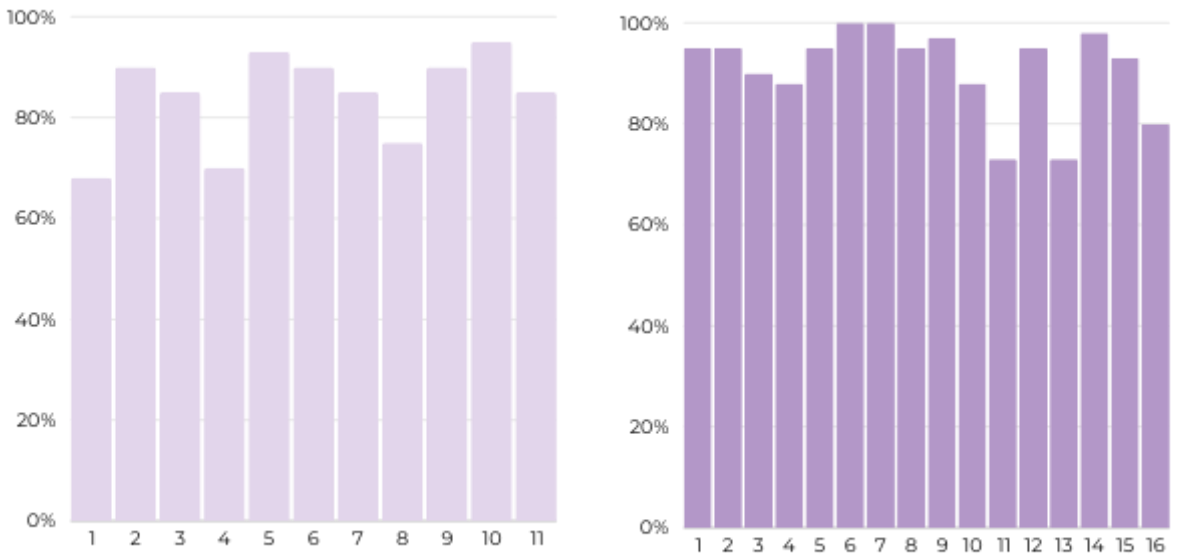
**Total Met standards (%)**




*Each bar represents an inpatient ward/unit

## Key Achievements

- **100%** of teams in both cycles met the standard that patients are able to personalise their bedroom spaces. Allowing for a more homely environment is essential for patients to be comfortable (2.2.15).
- In both cycles, it was found that all patients (**100%**) can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population (2.1.10).
- **69%** of teams in the 2022-2023 cycle reported that staff members and patients can control heating, ventilation and light (via direct switches or indirect requests), whereas only **36%** of teams in the earlier cycle were meeting this (2.1.3).

## Areas of Development

- For **73%** of services in the earlier cycle and **88%** of services in the latter cycle, staff members have access to a dedicated staff room (2.1.16).
- In the earlier cycle, **45%** of teams reported that patients are consulted about changes to the ward/unit environment and there was only a **9%** increase in the latter cycle (2.2.16).
- In the earlier cycle, **73%** of teams reported that staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms and there is an agreed response when an alarm is used. In the latter cycle, **56%** were meeting this standard (2.4.2).

# SECTION TWO: ENVIRONMENT AND FACILITIES

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 2.1.16**  | Ward/unit-based staff members have access to a dedicated staff room. | It is important that ward/staff members have a designated staff room that is easily accessible and promotes relaxation and interaction. On QED reviews, wards with staff rooms report how beneficial it is for staff morale. Teams can look to optimise other existing spaces, such as making makeshift staff rooms or convert unused rooms into staff rooms where there is comfortable seating, tables, a table, kettle or microwave for staff convenience. |
| **Standard 2.2.16**  | Patients are consulted about changes to the ward/unit environment. | Involving patients in the decision-making process is crucial. The team could ask patients during community meetings, to see how changes to the environment may impact patients' experience. The team could also look to create channels for patient feedback including suggestion boxes or surveys. On peer reviews, services have shared that patients have chosen furniture or wall colours, picked the name for rooms, or made suggestions about sensory considerations for patients with ASD. |
| **Standard 2.4.2**  | Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms and there is an agreed response when an alarm is used. | The team could add this to an admission checklist, so that patients, carers and new staff members are aware of the alarms, where they are located, how to use them and when they ought to be used. Staff should be trained regularly on how to use the alarms. |

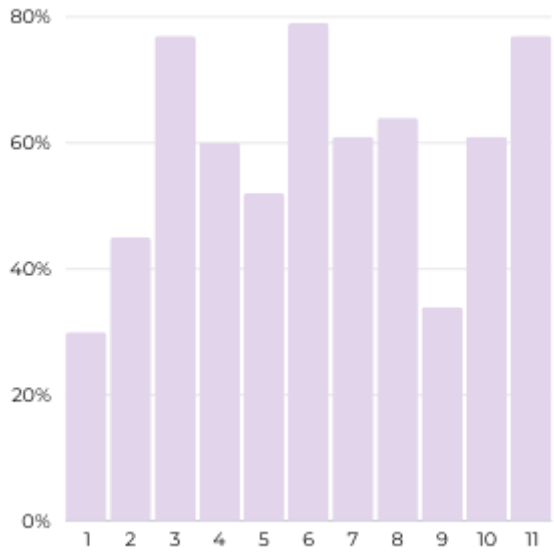
## Examples of Good Practice

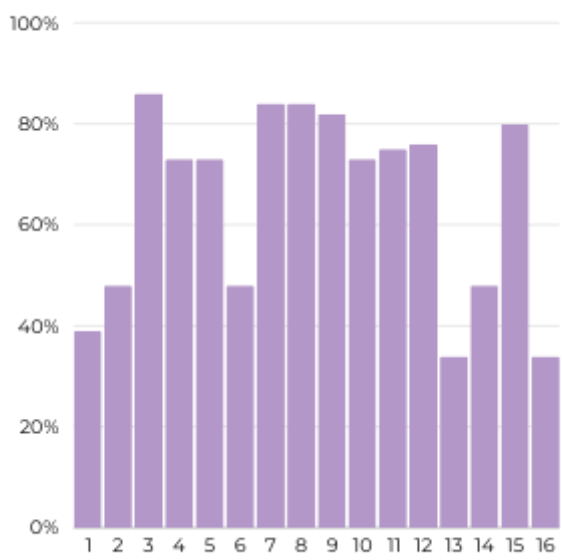
- Many teams have added artwork to the wards, creating a healing environment. The vibrant colours and diverse forms of art serve as a visual respite, transforming clinical spaces into warm and welcoming havens. Teams have felt that using patients' own artwork displayed within the ward validates their experiences and fosters a sense of pride.
- Outside the patient lounge for one particular service, there was a large mural that was completed by a patient which outlines different grounding techniques. Another team created a positivity tree with positive affirmations hanging off the branches.
- Many teams had spacious courtyards, where patients are encouraged to join gardening groups.
- Some wards encompassed two kitchens, one for patients to practice cooking in a therapeutic environment.

# SECTION THREE: STAFFING AND TRAINING

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | QED QUALITY NETWORK FOR EATING DISORDERS

**Total Met standards (%)**




*Each bar represents an inpatient ward/unit

## Key Achievements

- The number of specialist pharmacists joining multi-disciplinary teams is increasing. In the earlier cycle, **27%** of teams reported that a specialist pharmacist is a member of the MDT, whereas **56%** were meeting this standard in the latter cycle (3.1.7).
- In both cycles, **100%** of units evidenced that all staff members receive an annual appraisal and personal development planning (or equivalent) (3.3.1).
- In the latter cycle, **69%** of teams shared that they have protected time for team-building and discussing service development at least once a year, whereas **45%** were meeting this in the earlier cycle (3.3.8). As the pressures of the pandemic are easing, more teams are finding time to get together.

## Areas of Development

- **18%** of units in 2021-22 and **31%** in 2022-23 evidenced and met the standard concerning staff inductions, namely, that new staff members, including bank staff, receive an induction based on a list of core competencies and includes shadowing, joint working, and receiving enhanced supervision (3.2.2).
- **40%** of teams shared that patients and carers are involved in delivering and developing staff training in the earlier cycle, however this decreased by **15%** in the latter cycle (3.4.9).

# SECTION THREE: STAFFING AND TRAINING

| | Standard Criteria | Recommendation |
|---|---|---|
| **Standard 3.1.6**  | There is dedicated sessional input from creative therapists | Patients often feedback very positively on review days about the opportunity to engage in creative therapy, including art therapy, music therapy, dance/movement therapy or therapy with pets. The team could ask about patient's therapeutic needs, and if the MDT does not have a member of staff qualified in the requested therapeutic intervention, could invite professionals from local charities or VCSEs to run sessions on the ward. |
| **Standard 3.4.9**  | Patients and carers are involved in delivering and developing staff training face-to-face | Services could ensure any new training packages are co-produced with patients and carers. Former patients and parents/carers could be invited to training sessions to share their experiences of certain elements of care on the unit, or to share their thoughts on any opportunities for learning.<br><br>If patients or parents/carers would prefer not to attend training sessions in person, services could consider utilising virtual methods, such as audio and video clips recorded by them which can be included in staff training. |

## Example of Good Practice

- Staff emphasised that their service offers abundant educational opportunities, including in-house training, participation in a journal club, and access to external training. The ward staff expressed gratitude for the trust's wellbeing hub, which they can access at any time.

> ***Staff are amazing, marvellous and are doing the best they can!***
>
> ***- Patient***

# SECTION FOUR: CARE AND TREATMENT

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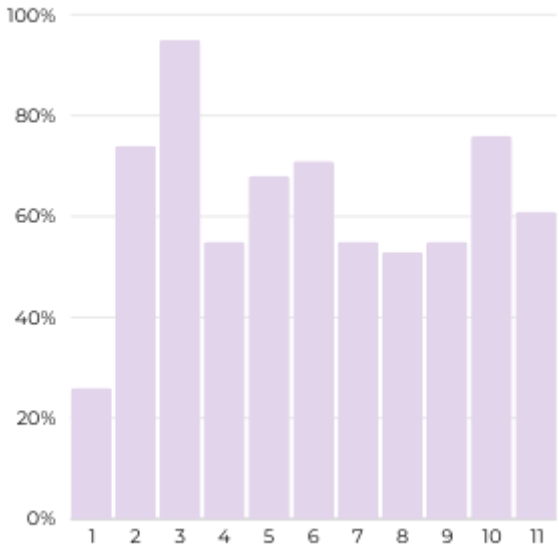
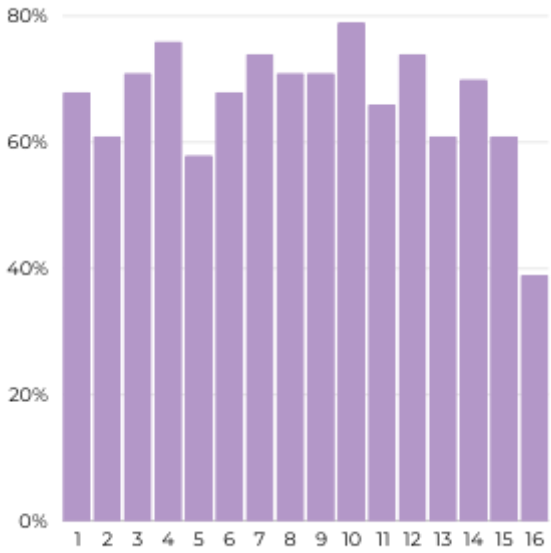
**Total Met standards (%)**

## 2021-2022




## 2022-2023




*Each bar represents an inpatient ward/unit

## Key Achievements

- In the 2022-23 cycle, **81%** of patients and their family/carers reported that they are able to contribute and express their views during formal reviews (CPA or equivalent) (4.4.1).
- In the 2021-22 cycle, **100%** of services reported that there is a ward community meeting that is attended by staff members and patients (4.2.2).
- **50%** of teams in the 2022-2023 cycle fully met and evidenced that patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality), and the assessment considers risk to self, risk to others and risk from others. However, this is a **32%** improvement from the previous cycle (4.1.3).

## Areas of Development

- **63%** (2022-2023 cycle) and **55%** (2021-2022 cycle) had developed a ratified care pathway for women who are pregnant or in the postpartum period (4.1.8).
- **45%** of teams in both cycles evidenced that staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare (4.7.2). This is an area that carers often highlight as being particularly challenging.
- **91%** of teams in the 2021-2022 cycle reported and evidenced that ward/unit staff provide post-meal/snack support to patients, appropriate to the individual's care plan. This dropped by **22%** in the 2022-2023 cycle (4.6.4).

# SECTION FOUR: CARE AND TREATMENT

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 4.1.1**  | Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. | It is common that care plans are not written with a patient or carer (with patient's consent) voice. Services should include the patient's voice where possible in their care plan to clearly show their collaboration. Where consent is not given for carers involvement in the care plan, this should be clearly indicated. Services could also add a section in the care plan, such as a tick box or signature box (which can be digital) to show that patients have a copy of the care plan, and whether they have accepted or declined the offer. |
| **Standard 4.1.8**  | The service has a care pathway for women who are pregnant or in the postpartum period. | Teams should have an eating disorder-specific policy or protocol (or operational policy) which clearly outlines what to do if a patient who is pregnant or in the post-partum period is admitted to the ward. This can include, but is not limited to referral pathways, clinicians involved, pre-birth plan advice, antenatal advice, pre-conceptual advice and post-natal care. |
| **Standard 4.6.1**  | Staff members ask patients for feedback about the food, and this is acted upon. | Services could ask for feedback, and ensure this is acted upon through surveys, suggestion boxes, suggestions on whiteboard/chalkboards, anonymous feedback through digital platforms, community meetings and one-to-one conversations. |
| **Standard 4.7.1**  | The team and patient jointly develop a leave plan, which is shared with the patient, that includes: A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; Conditions of the leave; Contact details of the ward/unit and crisis numbers. | Services commonly do not develop leave plans in collaboration with the patients. Services should include the patient's voice where possible in their leave plan to clearly show their collaboration. This should clearly indicate the risk assessment and management plan, which highlights what to do if problems arise. This should also include the conditions of leave, contact details of the ward and crisis numbers. |

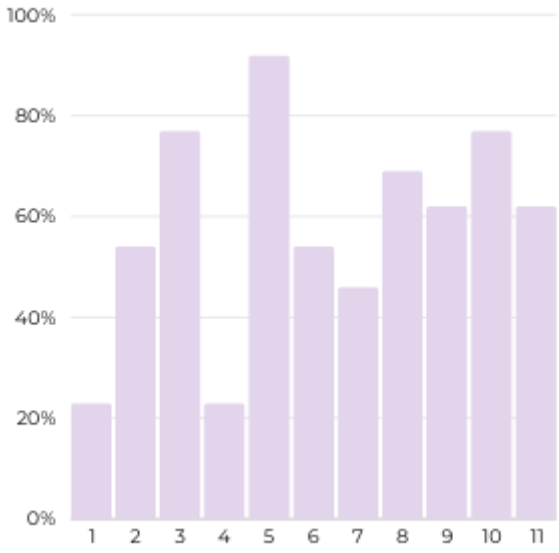
**Example of Good Practice**

One ward implemented an autism pathway and developed an autism 'quality standards pathway toolkit'. The primary aims were to develop a gold standard of operations and benchmark progress using the quality standards. The team developed an 'All About Me' booklet (like an autism passport) allowing patients to explore and community their preferences, differences and difficulties with staff.

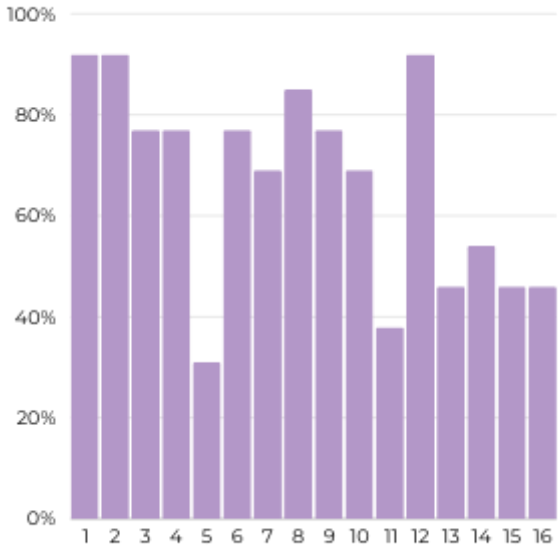
# SECTION FIVE: INFORMATION, CONSENT AND CONFIDENTIALITY

**Total Met standards (%)**

**2021-2022**




**2022-2023**




*Each bar represents an inpatient ward/unit

## Key Achievements

- **82%** of teams from the 2021-22 cycle reported that when talking to patients and their families/carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them (5.1.2). Teams could create a 'glossary' of specialist terms to add to the welcome pack to help support this.
- **100%** of standards around capacity and consent were met by all services in both cycles (5.3.2 & 5.3.3).

## Areas of Development

- **63%** of services offered patients (and carers with patient consent) written and verbal information about the patient's mental illness and treatment (5.2.4).
- Overall, both cycles showed lower compliance to standard 5.3.3: The team knows how to respond to carers when the patient does not consent to their involvement (**45%** and **50%** compliance).
- **44%** of teams in the latter cycle reported that carers are supported to access a statutory carers' assessment, provided by an appropriate agency, whereas **27%** were meeting this standard in the earlier cycle (5.2.6).

# SECTION FIVE: INFORMATION, CONSENT AND CONFIDENTIALITY

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 5.2.5**  | The service asks patients and carers for feedback about their experiences of using the service and this is used to improve the service. | This information should include the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities. |
| **Standard 5.2.6**  | Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. | Teams should promote awareness of the carers' assessment through adding it to an admission checklist, adding a section in carers' information packs, providing clear information on how to request an assessment and sharing contact details for relevant agencies. |
| **Standard 5.3.3**  | The team knows how to respond to carers when the patient does not consent to their involvement. | The service should hold a clear policy or protocol which shows how staff can respond to carers when the patient does not consent to their involvement. The service could develop a document for carers which includes information on confidentiality and information sharing, which clearly explains what the service can share and cannot share and the reasons for this, based on the Common Sense Confidentiality principles. This can also be added to the admission checklist, so that professionals can outline this to carers/family members upon admission. |

## Example of Good Practice

- One team used QR codes for carers information, so the initial letter was not too overwhelming with information.
- For one team, carers had been given support through carers groups including an online 6-week course delivered by a service user with lived experience.
- Carers at one service received their loved one's meal timetables and schedule for the day, enabling them to feel part of their loved one's journey.

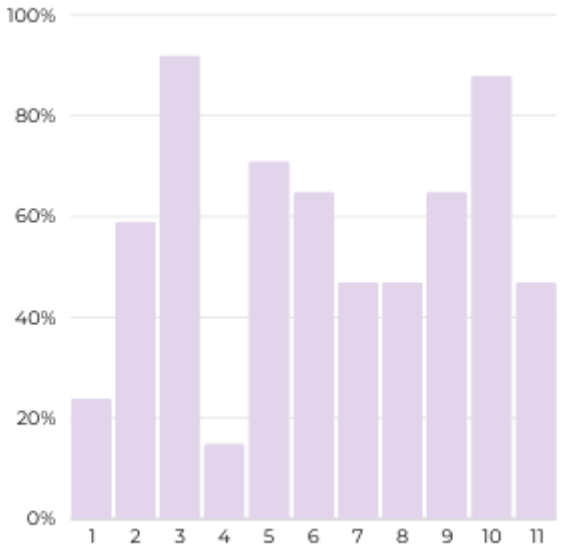
> ***I liked that I was given an admission pack that contained FAQs, a glossary of specialist terms and ex-patient's stories***
> ***- Patient***

# SECTION SIX: RIGHTS AND SAFEGUARDING

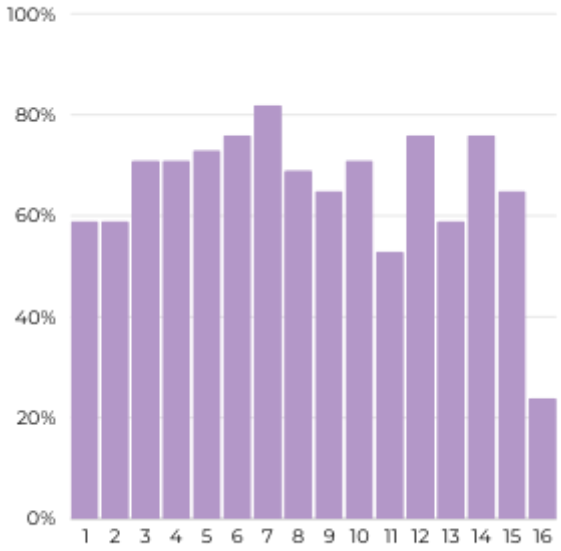
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | QED QUALITY NETWORK FOR EATING DISORDERS

**Total Met standards (%)**

## 2021-2022




## 2022-2023




*Each bar represents an inpatient ward/unit

## Key Achievements

- For the 2021-2022 cycle, **91%** of patients were reported to have access to relevant faith-specific support, through someone with an understanding of mental health issues (6.1.4)
- In the latter cycle, was a **20%** increase in compliance to standard 6.3.6 (to reduce the use of restrictive interventions, patients who have been violent or aggressive are supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions) compared to the earlier cycle.
- There was high compliance and evidence submitted for standard 6.1.1, 'staff members treat all patients and carers with dignity and respect', across both cycles.
- In the most recent cycle, 94% of services met the standard requiring that patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them (**6.2.4)**.

## Areas of Development

- In the 2022-2023 cycle, **81%** of teams met standard 6.1.3, stating that carers feel supported by ward staff members, while **45%** of teams in the 2021-2022 cycle were meeting the standard. There are recommendations for best practice on the next page.
- In the earlier cycle, **40%** teams reported and evidenced that staff, patients and carers who are affected by a serious incident including control and restraint and rapid tranquilisation are offered post incident support. Although this increased by **41%** in the latter cycle (6.3.9) this is an area of development for many services, and recommendations are made on the following page.

# SECTION SIX: RIGHTS AND SAFEGUARDING

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 6.3.2**  | Potential physical and psychological risks related to restraint are carefully assessed and mitigated. The team ensures this is: Clearly documented in the patient's notes; Reviewed regularly; Communicated to all MDT members; Evaluated with the patient and, where appropriate, their carer/advocate. | Services should engage in discussions with patients, and where appropriate, their carer or advocate (with the patient's consent), regarding the potential psychological risks associated with restraint. These discussions should be reviewed periodically and communicated to the multidisciplinary team (MDT). If consent is not granted for carer involvement, this should be explicitly documented in the patient's notes. The conversations should address how risk factors, sensory considerations, emotional and psychological aspects, and physical factors are managed to prepare those involved. |
| **Standard 6.3.4**  | Repeated restraint of a patient is reviewed and a second opinion is sought and recorded. | Service providers should adhere to a protocol or policy when repeated restraint becomes necessary. This protocol should outline how such situations will be managed and how a second opinion will be sought and documented. |
| **Standard 6.3.9**  | Staff members, patients and carers who are affected by a serious incident including control and restraint and rapid tranquilisation are offered post incident support. | Teams should follow a comprehensive post-incident protocol/policy which is reviewed regularly, as well as ensuring all staff members, patients and carers/family members are offered debrief sessions. Services could also add in care notes whether they have been offered debriefs in order have a clear record of this. |

## Example of Good Practice

**Engaging carers & chosen others:**
Standard **6.1.3** was often highlighted in previous cycles in the carer surveys as being a particular challenge. Inpatient units could:

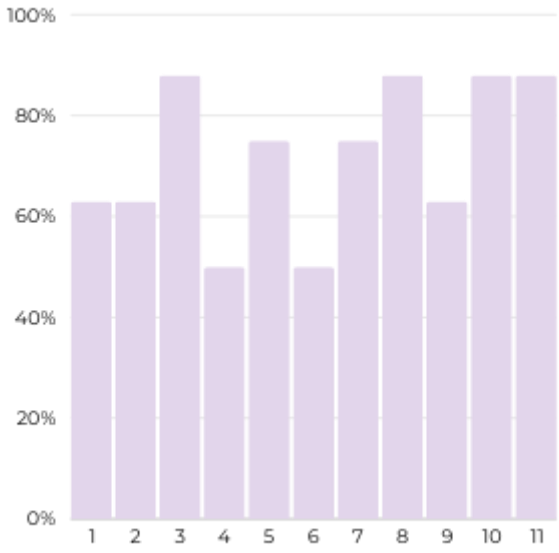
- identify a carer's champion
- allocate particular time per week to call carers (could be done pre-ward round to gather information)
- signpost them to resources and groups, make use of VCSE-based support

> ***All the staff members respect you. They appreciate everyone's stories and privacy.***
> ***- Patient***

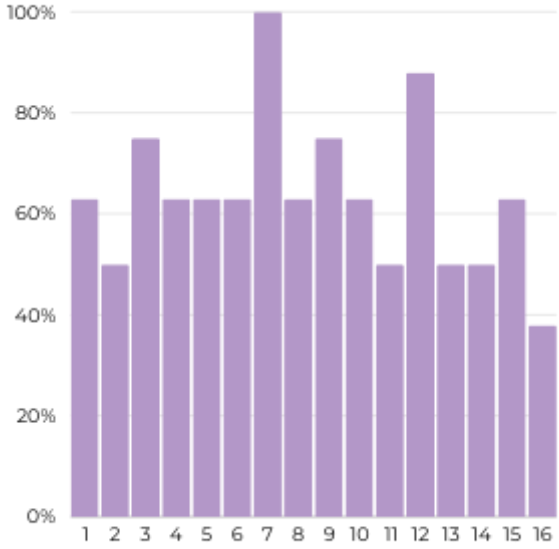
# SECTION SEVEN: DISCHARGE

**Total Met standards (%)**

## 2021-2022




## 2022-2023




*Each bar represents an inpatient ward/unit

## Key Achievements

- Teams across both cycles (**100%**) made sure that mental health practitioners carry out a thorough assessment of the patient's personal, social, safety and practical needs to reduce the risk of suicide on discharge (7.1.2).
- Teams across both cycles (**100%**) made sure that patients who are discharged from hospital have arrangements in place to be followed up within three days of discharge (7.1.5).
- Teams across both cycles (**100%**) ensured that When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible (7.1.7).

## Areas of Development

- **19%** of teams in the latter cycle reported that a discharge summary is sent within a week to the patient's GP and others concerned (with the patient's consent), including why the patient was admitted and how their condition has changed, diagnosis, medication and formulation. **64%** in the earlier cycle were meeting this standard (7.1.4).
- **25%** of teams in the latter cycle provided specific transition support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. **36%** of teams were meeting this standard in the earlier cycle (7.1.6).

# SECTION SEVEN: DISCHARGE

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 7.1.1** | Patients and their family/carer (with patient consent) are involved in decisions about discharge plans and are invited to a discharge meeting. | Services should have discussions with patients and their carer or advocate (with the patient's consent), regarding discharge planning. Both parties should be invited to a discharge meeting, and this information could be recorded on the discharge planning document. For instance:<br>-"Was the carer invited to a discharge meeting?" (Yes/No)<br>-"Did they attend?" (Yes/No)<br>If consent is not granted for carer involvement, this should be explicitly documented in the patient's notes.<br>Some services have also developed 'ending' or discharge groups for patients who are approaching the final parts of treatment to consider their transition back into the community and home life post-admission. |
| **Standard 7.1.6** | Teams provide specific transition support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. | When discussing transitions to another unit, community team or GP with patients, teams should adopt an individualised approach. This approach should prioritise the patients' specific needs and preferences, address medication management, maintain regular communication, provide access to advocacy services, and involve family and carers (with the patient's consent). It is also crucial to treat patients with dignity and respect throughout the process. |

## Example of Good Practice

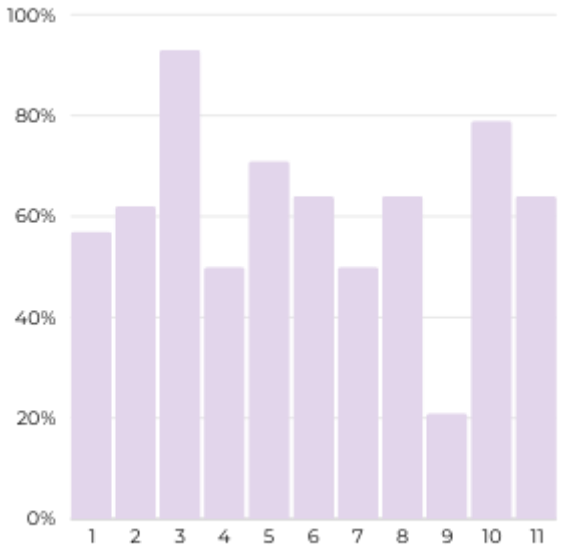
**"Spread your wings and fly"**

One team worked with a patient to overcome their anxiety around discharge and created a display of butterflies symbolising transformation and hope. Displaying artwork like this on the walls encourages the ethos throughout the unit's environment.

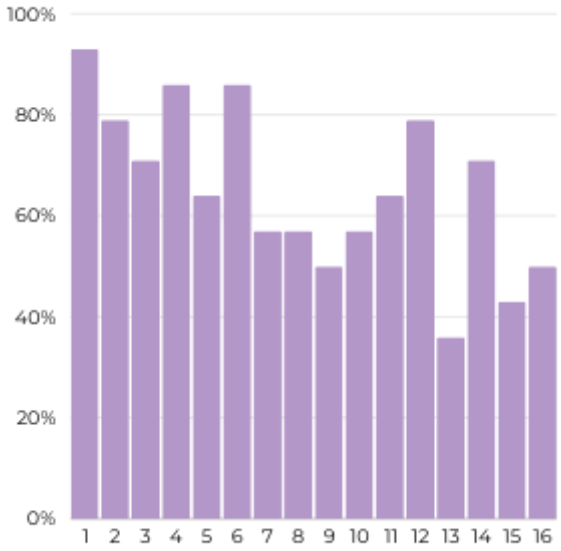
# SECTION EIGHT: CLINICAL GOVERNANCE

**Total Met standards (%)**

## 2021-2022




## 2022-2023




## Key Achievements

- A high number of teams in both cycles (**91%** and **100%**) had systems in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this (8.2.1).
- The number of teams using Quality Improvement methods to implement service improvements increased from 64% to 75% across the two cycles (8.2.7).
- **69%** of teams in the 2022-2023 cycle hold a well-attended business meeting at least monthly in which information and learning can be disseminated, and the unit's aims for care on the ward can be discussed. In the earlier cycle, just **36%** of teams were meeting this standard (8.2.6).

## Areas of Development

- In the 2022-2023 cycle, **50%** of teams were following an up to date lone working policy, with staff reporting that they feel safe when escorting patients on leave, whereas **91%** of teams were in the earlier cycle (8.1.2).
- Teams across both cycles had low compliance with standard 8.2.8 (**27%** and **31%** respectively), which states that the team actively encourages patients and carers to be involved in QI initiatives.
- Teams across both cycles had low compliance with standard 8.25, (**20%** and **25%**) which states that services are developed in partnership with appropriately experienced patient and carers who have an active role in decision making.

# SECTION EIGHT: CLINICAL GOVERNANCE

| | Standard Criteria | Recommendations |
|---|---|---|
| **Standard 8.2.4**  | The service asks patients and carers for feedback about their experiences of using the service and this is used to improve the service. | Teams should regularly solicit feedback from patients and carers using methods such as surveys, interviews, focus groups or service improvement discussions. Teams could also consider leveraging digital platforms such as patient portals and social media channels. To ensure feedback is acted upon, teams should look for patterns, common themes and areas for improvement. |
| **Standard 8.2.5**  | Services are developed in partnership with appropriately experienced patient and carers who have an active role in decision making. | Services should collaborate with patients and carers who have relevant experience and actively involve them in decision-making. For instance, an "expert by experience" could participate in meetings such as governance, steering, or advisory groups to ensure their perspectives are heard, and their ideas and feedback are acted upon. |
| **Standard 8.2.8**  | The team actively encourages patients and carers to be involved in QI initiatives. | Services could actively involve patients and carers in the planning and design of QI initiatives. Services can also involve former patients or carers and regularly update them on QI progress and outcomes. Some services have previously involved patients and carers in updating information/admission packs. |

## Example of Good Practice

- Some teams have been utilising a "you said, we did" board on wards, which is a great way to update patients on changes being made and encouraging feedback that may initiate change.
- Other services have run patient community groups every week to generate ideas from patients and improve co-production.
- One service developed a 'how you can support me' document which patients complete. This has been beneficial for staff as they can re-refer to the resource which outlines patient's self-identified likes, dislikes and triggers. They have also developed an 'all about me' document for both patients and staff members including a brief of who they are, what they like to be called, what they were doing before, what they like to do and what they don't like others to say.

# 4TH EDITION INPATIENT STANDARDS

Both the inpatient and community standards are reviewed every two years to improve the standards validity and accessibility. In December 2023, QED published the QED 4th Edition inpatient standards. Regularly reviewing the QED standards is essential to ensure they stay practical and applicable to the evolving requirements of this population.

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes patient/carer representatives, staff from the Royal College of Psychiatrists, QED inpatient services, QED Advisory Group and the QED Accreditation Committee and relevant VCSEs. They incorporate the College Centre for Quality Improvement (CCQI) Core Inpatient Standards, as well as specialist standards relating specifically to inpatient eating disorder services. The fourth edition of the QED quality standards for inpatient eating disorder services has also been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

**Who are these standards for?** These standards are designed to be applicable to inpatient eating disorder services and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

**Some noteworthy changes (from 3rd to 4th ed. Standards) include:**

- The inclusion of more Type 3 standards to ensure they are desirable standards that high performing standards ought to meet, whilst recognising that these are aspirational and accredited services need only to meet 60%.
- Incorporated changes to Core standards which promote inclusivity.
- Removal of specific QED standards based on consultation and feedback from reviews.
- Guidance added to standards to clarify the standards that were causing confusion on review days.
- Survey questions updated to reflect members' feedback.

**Notes from the QED Advisory Group Chair**

*The Quality Network for Eating Disorders (QED) was established in 2012 to provide eating disorder services across the UK with a framework to guide the delivery of safe, effective and evidence-based care for people with eating disorders and their carers.*
*Standards are reviewed every two years, with service users, carers and eating disorder clinicians from across the UK.*

*Through the accreditation process facilitated by QED, services are provided with guidance and support to reach the highest quality of care. Alongside this, the peer review process provides opportunities for clinicians to meet and share areas of good practice and innovati developments in healthcare.*

# Appendix 1: All standards data (2022 – 2023)

| 1 | | Section 1 Access And Admission | Percentage Met |
|---|---|---|---|
| 1.1 | | Access And Referral | |
| 1.1.1 | 1 | The service provides information about how to make a referral. | 75% |
| 1.1.2 | 1 | Where part of a provider collaborative, the ward follows an agreed standard operating procedure around managing standards for referral. | 81% |
| 1.1.3 | 2 | For patients referred for admission by a non-specialist service, the ward/unit provides expert advice if a bed is not available to support patient safety. This might include providing face-to-face and telephone consultation, written protocols, input into care plans etc. | 88% |
| 1.1.4 | 1 | The unit admits both male and female patients. | 73% |
| 1.2 | | Initial Assessment | |
| 1.2.1 | 1 | Patients have a comprehensive mental health assessment which is started within four hours and completed within one week. This involves the multi-disciplinary team and includes consideration of the patient's:<br><br>Mental health and medication;<br><br>Psychosocial and psychological needs;<br><br>Strengths and areas for development. | 94% |
| 1.2.2 | 1 | Patients have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. The assessment is completed within one week, or prior to discharge. | 94% |
| 1.2.3 | 1 | Patients are informed of the outcome of their physical health assessment and this is recorded in their notes. | 44% |
| 1.2.4 | 1 | As part of the initial assessment, assessment is made of the risk factors for refeeding syndrome, appropriate action is taken if indicated, and this is recorded. | 100% |
| 1.2.5 | 1 | On admission the following is given consideration:<br><br>The security of the patient's home;<br><br>Arrangements for dependants (children, people they are caring for);<br><br>Arrangements for pets;<br><br>Essential maintenance of home and garden. | 100% |

| | | | |
|---|---|---|---|
| **1.2.6** | 2 | **A formal written report follows within 14 days of assessment with the service.** | **25%** |
| **1.2.7** | 1 | **In the case of non-attendance, the ward/unit contacts the referrer immediately to inform, ascertain the patient's level of risk, and agree a plan.** | **100%** |
| **1.2.8** | 1 | **There is a documented Care Programme Approach (or equivalent) or ward round admission meeting within one week of the patient's admission. Patients are supported to attend this with advanced preparation and feedback.** | **38%** |
| **1.2.9** | 2 | **A representative from the community eating disorder team is invited to attend the first review.** | **94%** |
| **1.2.10** | 2 | **The ward/unit provides written feedback to referrers a minimum of once every six weeks.** | **56%** |
| **1.3** | | **Support Through The Admission Process** | |
| **1.3.1** | 2 | **Patients and their families/carers are invited to visit the ward/unit prior to admission.** | **19%** |
| **1.3.2** | 1 | **On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital.** | **100%** |
| **1.3.3** | 1 | **The patient's carer is contacted by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details.** | **56%** |
| **1.3.4** | 2 | **Carers are offered individual time with staff members within 48 hours of the patient's admission to discuss concerns, family history and their own needs.** | **31%** |
| **1.3.5** | 3 | **The service can signpost to nearby facilities for their family/carers to stay overnight when appropriate, and can advise on available funding.** | **19%** |
| **1.3.6** | 1 | **When a young person under the age of 18 is admitted:**<br><br>**There is a named CAMHS clinician who is available for consultation and advice;**<br><br>**The local authority or local equivalent is informed of the admission;**<br><br>**The CQC or local equivalent is informed if the patient is detained;**<br><br>**A single room is used.** | **60%** |
| **1.3.7** | 1 | **People admitted to the ward outside the area in which they live have a review of their placement at least every three months.** | **100%** |
| **2** | | **Section 2 Environment And Facilities** | **Percentage Met** |
| **2.1** | | **The Ward/Unit Is Well Designed And Has The Necessary Facilities And Resources** | |
| **2.1.1** | 2 | **The ward/unit entrance and key clinical areas are clearly signposted.** | **100%** |
| **2.1.2** | 1 | **The unit is clean, comfortable and well-maintained.** | **100%** |
| **2.1.3** | 2 | **Staff members and patients can control heating, ventilation and light.** | **69%** |
| **2.1.4** | 2 | **The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.** | **100%** |
| **2.1.5** | 1 | **The ward/unit has a designated dining area, which is reserved for dining only during allocated mealtimes.** | **100%** |
| **2.1.6** | 2 | **The dining area is big enough to allow patients to eat in comfort and to encourage social interaction, including the ability for staff to engage with and observe patients during mealtimes.** | **94%** |
| **2.1.7** | 2 | **The ward/unit has a designated room for physical examination and minor medical procedures.** | **100%** |

| | | | |
|---|---|---|---|
| **2.1.8** | 1 | **The team keeps medications in a secure place, in line with the organisation's medicine management policy.** | **100%** |
| **2.1.9** | 2 | **Laundry facilities are available to all patients.** | **100%** |
| **2.1.10** | 2 | **All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population.** | **100%** |
| **2.1.11** | 1 | **Patients have access to safe outdoor space every day.** | **94%** |
| **2.1.12** | 2 | **There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements.** | **75%** |
| **2.1.13** | 3 | **All patients can access a charge point for electronic devices such as mobile phones.** | **100%** |
| **2.1.14** | 2 | **There is at least one room for interviewing and meeting with individual patients and relatives, which is furnished with comfortable seating.** | **94%** |
| **2.1.15** | 2 | **There is a designated space for patients to receive visits from children, with appropriate facilities such as toys, books.** | **100%** |
| **2.1.16** | 2 | **Ward/unit-based staff members have access to a dedicated staff room.** | **88%** |
| **2.2** | | **Premises Are Designed And Managed So That Patients' Rights, Privacy And Dignity Are Respected** | |
| **2.2.1** | 1 | **The environment complies with current legislation on disabled access.** | **100%** |
| **2.2.2** | 1 | **All patient information is kept in accordance with current legislation.** | **100%** |
| **2.2.3** | 1 | **Male and female patients have separate bedrooms, toilets and washing facilities.** | **100%** |
| **2.2.4** | 2 | **All patients have single bedrooms.** | **100%** |
| **2.2.5** | 1 | **Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom except in emergencies or where there are concerns about the patient's well-being.** | **81%** |
| **2.2.6** | 2 | **There is secure, lockable access to a patient's room, with external staff override.** | **94%** |
| **2.2.7** | 2 | **The ward/unit has at least one bathroom/shower room for every three patients.** | **87%** |
| **2.2.8** | 3 | **Every patient has an en-suite bathroom.** | **63%** |
| **2.2.9** | 1 | **Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room, access to groups.** | **81%** |
| **2.2.10** | 2 | **In spaces where personal and confidential discussions are held, such as interview rooms and consulting/examination/treatment spaces, conversations cannot be heard outside of the room.** | **94%** |
| **2.2.11** | 2 | **Consideration is given to reduce the impact of a noisy environment on patients.** | **69%** |
| **2.2.12** | 1 | **There is a separable gender-specific space which can be used as required.** | **93%** |

| | | | |
|---|---|---|---|
| **2.2.13** | 1 | **Patients can make and receive telephone calls in private.** | **94%** |
| **2.2.14** | 1 | **Patients use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and in line with local policy.** | **94%** |
| **2.2.15** | 2 | **Patients are able to personalise their bedroom spaces.** | **100%** |
| **2.2.16** | 2 | **Patients are consulted about changes to the ward/unit environment.** | **56%** |
| **2.3** | | **The Unit Provides A Safe Environment For Staff And Patients** | |
| **2.3.1** | 1 | **Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety.** | **88%** |
| **2.3.2** | 1 | **The ward is a safe environment with no ligature points, clear sightlines (e.g. with use of mirrors) and safe external spaces.** | **81%** |
| **2.3.3** | 2 | **Doors have viewing panels or observation windows and their use is managed to balance privacy and safety.** | **88%** |
| **2.3.4** | 1 | **Patients and staff members feel safe on the ward.** | **100%** |
| **2.4** | | **Equipment And Procedures For Dealing With Emergencies On The Unit Are In Place** | |
| **2.4.1** | 1 | **The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.** | **100%** |
| **2.4.2** | 1 | **Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms, or personal alarms and there is an agreed response when an alarm is used.** | **56%** |
| **2.4.3** | 1 | **Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.** | **100%** |
| **2.4.4** | 1 | **Hypostop or equivalent is available on the ward/unit, with guidance on its safe use.** | **100%** |
| **3** | | **Section 3 Staffing And Training** | **Percentage Met** |
| **3.1** | | **The Ward/Unit Comprises A Core Multi-Disciplinary Team** | |
| **3.1.1** | 1 | **The ward/unit has its own dedicated consultant psychiatrist for eating disorders who will provide expert input into key matters of service delivery, staff support and supervision, and coordination of patient care.** | **81%** |
| **3.1.2** | 1 | **There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency.** | **81%** |
| **3.1.3** | 1 | **There is a dietitian who is part of the MDT. They contribute to the assessment and formulation of the patients' nutritional needs and the safe and effective provision of evidence-based nutritional interventions.** | **100%** |

| | | | |
|---|---|---|---|
| **3.1.4** | 1 | **There is a psychologist who is part of the MDT. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence-based psychological interventions.** | **88%** |
| **3.1.5** | 1 | **There is an occupational therapist who is part of the MDT. They work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence-based occupational interventions.** | **100%** |
| **3.1.6** | 3 | **There is dedicated sessional input from creative therapists.** | **44%** |
| **3.1.7** | 2 | **A specialist pharmacist is a member of the MDT.** | **56%** |
| **3.1.8** | 1 | **There are written documents that specify professional, organisational and line management responsibilities.** | **81%** |
| **3.1.9** | 1 | **Full MDT clinical review meetings occur at least once a week.** | **100%** |
| **3.2** | | **Staff Working On The Unit Undergo A Formal Induction Process** | |
| **3.2.1** | 1 | **All staff, including temporary/agency staff, have a comprehensive induction to the ward/unit, which covers key aspects of care.** | **44%** |
| **3.2.2** | 1 | **New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes:**<br><br>**Arrangements for shadowing colleagues on the team;**<br>**Jointly working with a more experienced colleague;**<br>**Being observed and receiving enhanced supervision until core competencies have been assessed as met.** | **31%** |
| **3.3** | | **There Are Processes In Place To Ensure That Staff Performance And Wellbeing Are Monitored** | |
| **3.3.1** | 1 | **All staff members receive an annual appraisal and personal development planning (or equivalent).** | **100%** |
| **3.3.2** | 1 | **All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.** | **94%** |
| **3.3.3** | 2 | **All staff members receive line management supervision at least monthly.** | **63%** |
| **3.3.4** | 2 | **Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice.** | **56%** |
| **3.3.5** | 2 | **Staff members in training and newly qualified staff members are offered weekly supervision and supported to attend.** | **63%** |
| **3.3.6** | 1 | **The ward/unit actively supports staff health and well-being.** | **100%** |
| **3.3.7** | 1 | **Staff members are able to take breaks during their shift that comply with the European Working Time Directive.** | **100%** |

| | | | |
|---|---|---|---|
| **3.3.8** | 2 | **The team has protected time for team-building and discussing service development at least once a year.** | **69%** |
| **3.4** | | **Staff Are Provided With A Thorough Programme Of Training, Relevant To An Eating Disorder Setting** | |
| **3.4.1a** | 1 | **Statutory and mandatory training.** | **50%** |
| **3.4.1b** | 1 | **The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).** | **69%** |
| **3.4.1c** | 1 | **Safeguarding vulnerable adults and children.** | **69%** |
| **3.4.1d** | 1 | **Prevention and management of violence and aggression, including the use of restraint for nasogastric feeding.** | **50%** |
| **3.4.1e** | 1 | **Risk assessment and risk management.** | **63%** |
| **3.4.1f** | 1 | **Physical health assessment.** | **63%** |
| **3.4.1g** | 1 | **Recognising and communicating with patients with autistic spectrum disorders.** | **56%** |
| **3.4.1h** | 1 | **Managing distorted perceptions of food and body image.** | **63%** |
| **3.4.1i** | 1 | **Managing clients with co-morbidity and understanding the impact of trauma within eating disorders.** | **63%** |
| **3.4.1j** | 2 | **Care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning.** | **63%** |
| **3.4.1k** | 2 | **Carer support and awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.** | **53%** |
| **3.4.1l** | 2 | **Clinical outcome measures.** | **47%** |
| **3.4.2** | 2 | **Staff members are supported to access leadership and management training appropriate to their role and specialty.** | **81%** |
| **3.4.3** | 1 | **All staff members who administer medications have been assessed as competent to do so. Assessment is done using a competency-based tool. This assessment is repeated at least once every three years.** | **56%** |
| **3.4.4** | 2 | **Clinical staff who are involved in the day-to-day care of adults with eating disorders receive basic eating disorder-specific training on psychoeducation, motivational enhancement and working with families.** | **56%** |
| **3.4.5** | 2 | **Staff who are involved in supporting patients' mealtimes have been trained in meal and post-meal support.** | **63%** |
| **3.4.6** | 1 | **Staff implementing enteral feeding are trained using a competency-based framework and assessed a minimum of annually.** | **50%** |
| **3.4.7** | 1 | **All staff undergo specific training in therapeutic observation (including principles around positive engagement with patients, when to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this and actions to take if the patient absconds) when they join the service as part of their induction or change wards.** | **56%** |

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| **3.4.8** | 1 | **All staff members who deliver therapies and activities are appropriately trained and supervised.** | **19%** |
| **3.4.9** | 2 | **Patients and carers are involved in delivering and developing staff training face-to-face.** | **25%** |
| **3.5** | | **The Levels Of Staff On The Unit Are Safe And Sufficient To Meet The Needs Of The Patients At All Times** | |
| **3.5.1** | 1 | **The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:**<br><br>**A method for the team to report concerns about staffing levels;**<br><br>**Access to additional staff members;**<br><br>**An agreed contingency plan, such as the minor and temporary reduction of non-essential services.** | **38%** |
| **3.5.2** | 2 | **The ward/unit is staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need.** | **31%** |
| **3.5.3** | 2 | **Appropriately experienced patient or carer representatives are involved in the interview process for recruiting potential staff members.** | **13%** |
| **3.5.4** | 1 | **Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.** | **100%** |
| **3.5.5** | 1 | **When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.** | **100%** |
| **4** | | **Section 4 Care And Treatment** | **Percentage Met** |
| **4.1** | | **Care Planning** | |
| **4.1.1** | 1 | **Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy.** | **25%** |
| **4.1.2** | 1 | **All patients have a documented diagnosis and a clinical formulation.** | **94%** |
| **4.1.3** | 1 | **Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.** | **50%** |
| **4.1.4** | 1 | **Patients are offered personalised healthy lifestyle interventions appropriate to an eating disorder setting, such as advice on appropriate physical activity and access to smoking cessation services. This is documented in the patient's care plan.** | **56%** |
| **4.1.5** | 1 | **Patients with poor personal hygiene have a care plan that reflects their personal care needs.** | **100%** |
| **4.1.6** | 3 | **The team supports patients to attend other health and social care-related appointments as an inpatient, when necessary.** | **69%** |

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| **4.1.7** | 1 | **The ward/unit has access to specialist services to treat co-morbid conditions (including substance misuse), and staff are aware of how to access these services.** | **88%** |
| **4.1.8** | 1 | **The service has a care pathway for women who are pregnant or in the postpartum period.** | **63%** |
| **4.2** | | **Programme Of Care And Treatment** | |
| **4.2.1** | 1 | **Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within two weeks of admission. Any exceptions are documented in the case notes.** | **100%** |
| **4.2.2** | 1 | **Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with.** | **56%** |
| **4.2.3** | 2 | **There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group.** | **81%** |
| **4.2.4** | 2 | **Patients receive psychoeducation on topics about activities of daily living, for example, interpersonal communication, relationships, coping with stigma, stress management and anger management.** | **31%** |
| **4.2.5** | 2 | **The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and may include access to:**<br><br>**Voluntary organisations;**<br><br>**Community centres;**<br><br>**Local religious/cultural groups;**<br><br>**Peer support networks;**<br><br>**Recovery colleges** | **31%** |
| **4.2.6** | 1 | **The team supports patients to access support with finances, benefits, debt management and housing.** | **63%** |
| **4.3** | | **Physical Health** | |
| **4.3.1** | 1 | **Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission.** | **100%** |
| **4.3.2** | 1 | **Weighing is carried out regularly (no more than twice a week) and is documented. If weighing is undertaken more frequently, there is a clear clinical rationale.** | **100%** |
| **4.3.3** | 1 | **Patients in the early stages of refeeding are monitored closely for signs of biochemical, cardiovascular and fluid balance disturbance.** | **100%** |
| **4.4** | | **Patient And Carer Involvement** | |
| **4.4.1** | 1 | **Patients and their family/carers are able to contribute and express their views during formal reviews (CPA or equivalent).** | **88%** |
| **4.4.2** | 1 | **Actions from reviews are fed back to the patient (and their family/carer, with the patient's consent) and this is documented.** | **50%** |
| **4.4.3** | 1 | **Each patient receives a pre-arranged 1-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.** | **31%** |

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| **4.4.4** | 1 | **Patients know who the key people are in their team and how to contact them if they have any questions.** | **81%** |
| **4.4.5** | 1 | **Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.** | **63%** |
| **4.4.6** | 2 | **The ward/unit encourages current or former patients to facilitate recovery and other groups to foster an environment of mutual support.** | **47%** |
| **4.4.7** | 2 | **Carers are encouraged to meet with other carers from the ward/unit as part of a carers support group.** | **38%** |
| **4.5** | | **Medication** | |
| **4.5.1** | 2 | **When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.** | **56%** |
| **4.5.2** | 1 | **Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects, adherence to medication regime, and effectiveness in the context of an eating disorder.** | **100%** |
| **4.5.3** | 1 | **Every patient's PRN medication is reviewed weekly, with consideration of the frequency, dose and reasons.** | **100%** |
| **4.5.4** | 1 | **Patients in hospital for long periods of time, who are prescribed mood stabilisers or antipsychotics, have the appropriate physical health assessments at the start of treatment (baseline), at six weeks,at three months and then annually (or every six months for young people) unless a physical health abnormality arises.** | **100%** |
| **4.6** | | **Food** | |
| **4.6.1** | 1 | **Staff members ask patients for feedback about the food and this is acted upon.** | **19%** |
| **4.6.2** | 3 | **The food is freshly cooked on the hospital premises, rather than being reheated.** | **63%** |
| **4.6.3** | 1 | **Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements. Meals are varied and reflect the individual's cultural, religious and ethical needs.** | **56%** |
| **4.6.4** | 1 | **Ward/unit staff provide post-meal/snack support to patients, appropriate to the individual's care plan.** | **69%** |
| **4.7** | | **Leave** | |
| **4.7.1** | 1 | **The team and patient jointly develop a leave plan, which is shared with the patient, that includes:**<br><br>**A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave;**<br><br>**Conditions of the leave;**<br><br>**Contact details of the ward/unit and crisis numbers.** | **38%** |

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| **4.7.2** | 1 | **Staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare.** | **44%** |
| **4.7.3** | 2 | **Patients have supported periods of home leave to develop independent eating and self-management well in advance of discharge.** | **44%** |
| **4.7.4** | 1 | **When patients are absent without leave, the team (in accordance with local policy):**<br><br>**Activate a risk management plan;**<br><br>**Make efforts to locate the patient;**<br><br>**Alert carers, people at risk and the relevant authorities;**<br><br>**Complete an incident form** | **75%** |
| **4.8** | | **Clinical Outcome Measurement** | |
| **4.8.1** | 1 | **Clinical outcome measurement, and progress against user defined goals is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.** | **100%** |
| **4.8.2** | 2 | **Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.** | **69%** |
| **5** | | **Section 5 Information, Consent And Confidentiality** | **Percentage Met** |
| **5.1** | | **Information Is Accessible For All** | |
| **5.1.1** | 1 | **Information, which is accessible and easy to understand, is provided to patients and their family/carers.** | **81%** |
| **5.1.2** | 1 | **When talking to patients and their families/carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them.** | **75%** |
| **5.1.3** | 2 | **The ward/unit uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.** | **50%** |
| **5.1.4** | 1 | **All patients have access to an advocacy service including IMHAs (Independent Mental Health Advocates).** | **81%** |
| **5.2** | | **Patients And Carers Are Provided With All Key Information** | |
| **5.2.1** | 1 | **The patient is given an information pack on admission that contains the following:**<br><br>**A description of the service;**<br><br>**The therapeutic programme;**<br><br>**Information about the staff team;**<br><br>**The unit code of conduct;**<br><br>**Key service policies (e.g. permitted items, smoking policy);**<br><br>**Resources to meet spiritual, cultural or gender needs.** | **56%** |

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| **5.2.2** | 1 | **Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:**<br><br>**Their rights regarding admission and consent to treatment;**<br><br>**Rights under the Mental Health Act;**<br><br>**How to access advocacy services;**<br><br>**How to access a second opinion;**<br><br>**Interpreting services;**<br><br>**How to view their records;**<br><br>**How to raise concerns, complaints and give compliments.** | **50%** |
| **5.2.3** | 1 | **Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.** | **63%** |
| **5.2.4** | 1 | **Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment.** | **56%** |
| **5.2.5** | 2 | **The team provides each carer with carer's information.** | **63%** |
| **5.2.6** | 1 | **Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.** | **44%** |
| **5.3** | | **Consent** | |
| **5.3.1** | 1 | **Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation.** | **100%** |
| **5.3.2** | 1 | **When patients lack capacity to consent to interventions, decisions are made in their best interests.** | **100%** |
| **5.3.3** | 1 | **The team knows how to respond to carers when the patient does not consent to their involvement.** | **50%** |
| **6** | | **Section 6 Rights And Safeguarding** | **Percentage Met** |
| **6.1** | | **Compassion, Dignity And Respect** | |
| **6.1.1** | 1 | **Staff members treat all patients and carers with compassion, dignity and respect.** | **94%** |
| **6.1.2** | 1 | **Patients feel listened to and understood by staff members.** | **88%** |
| **6.1.3** | 2 | **Carers feel supported by the ward staff members.** | **81%** |
| **6.1.4** | 2 | **Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.** | **75%** |

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| **6.2** | | **Safeguarding** | |
| **6.2.1** | 1 | **Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.** | **50%** |
| **6.2.2** | 1 | **Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.** | **100%** |
| **6.2.3** | 1 | **Patients are involved in decisions about their level of observation by staff.** | **56%** |
| **6.2.4** | 2 | **Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.** | **94%** |
| **6.3** | | **Restrictive Practice** | |
| **6.3.1** | 1 | **The team uses seclusion or segregation only as a last resort and for brief periods only.** | **20%** |
| **6.3.2** | 1 | **Potential physical and psychological risks related to restraint are carefully assessed and mitigated. The team ensures this is:- Clearly documented in the patient's notes;- Reviewed regularly;- Communicated to all MDT members;- Evaluated with the patient and, where appropriate, their carer/advocate.** | **31%** |
| **6.3.3** | 1 | **Staff members do not restrain patients in a way that affects their airway, breathing or circulation.** | **44%** |
| **6.3.4** | 1 | **Repeated restraint of a patient is reviewed and a second opinion is sought and recorded.** | **19%** |
| **6.3.5** | 1 | **The multi-disciplinary team collects audit data on the use of restrictive interventions and actively works to reduce its use year on year.** | **31%** |
| **6.3.6** | 1 | **To reduce the use of restrictive interventions, patients who have been violent or aggressive are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions.** | **47%** |
| **6.3.7** | 1 | **Patients who are involved in episodes of control and restraint, or compulsory treatment including tranquilisation, have their vital signs including respiratory rate monitored by staff members and any deterioration is responded to.** | **100%** |
| **6.3.8** | 1 | **Restraint to feed and/or nasogastric bridles is only be used in life-threatening situations or as part of a carefully considered multi-disciplinary care plan, which is reviewed at every ward round/review.** | **100%** |
| **6.3.9** | 1 | **Staff members, patients and carers who are affected by a serious incident including control and restraint and rapid tranquilisation are offered post incident support.** | **81%** |

| 7 | | Section 7 Discharge | Percentage Met |
|---|---|---|---|
| 7.1 | | Discharge Plans Are Agreed With And Communicated To All Relevant Parties | |
| 7.1.1 | 1 | Patients and their family/carer (with patient consent) are involved in decisions about discharge plans and are invited to a discharge meeting. | 31% |
| 7.1.2 | 1 | Mental health practitioners carry out a thorough assessment of the patient's personal, social, safety and practical needs to reduce the risk of suicide on discharge. | 100% |
| 7.1.3 | 1 | Patients discharged from inpatient care have their care plan or interim discharge summary sent to everyone identified in the plan as involved in their ongoing care within 24 hours of discharge. | 38% |
| 7.1.4 | 2 | A discharge summary is sent within a week to the patient's GP and others concerned (with the patient's consent), including why the patient was admitted and how their condition has changed, diagnosis, medication and formulation. | 19% |
| 7.1.5 | 1 | The inpatient team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within three days of discharge. | 100% |
| 7.1.6 | 3 | Teams provide specific transition support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. | 25% |
| 7.1.7 | 1 | When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible. | 100% |
| 7.1.8 | 2 | If a patient requires transfer to another ward/unit (either for physical or mental health needs), the eating disorder service ensures that nutritional and psychosocial support are maintained and are MARSIPAN-compliant. | 94% |
| 8 | | Section 8 Clinical Governance | Percentage Met |
| 8.1 | | A Comprehensive Range Of Policies Is In Place | |
| 8.1.1 | 2 | Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use. | 100% |
| 8.1.2 | 1 | Staff members follow a lone working policy and feel safe when escorting patients on leave. | 50% |
| 8.1.3 | 1 | There is a visiting policy which includes procedures to follow for specific groups including:- Children;- Unwanted visitors (i.e. those who pose a threat to patients, or to staff members). | 75% |

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| **8.1.4** | 1 | **There is a policy that states that oral refeeding is the preferred method, and there is a policy for when oral feeding is used and when enteral feeding is used.** | **69%** |
| **8.1.5** | 1 | **There is a written protocol for how to manage the nutritional components of refeeding, which is jointly overseen by a nurse and dietitian and emphasises the need to avoid under-nutrition.** | **63%** |
| **8.1.6** | 1 | **There is a policy on the assessment and management of pressure sores.** | **69%** |
| **8.2** | | **The Ward/Unit Learns From Feedback, Complaints And Incidents** | |
| **8.2.1** | 1 | **Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.** | **100%** |
| **8.2.2** | 1 | **When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.** | **50%** |
| **8.2.3** | 1 | **Lessons learned from incidents are shared with the team and disseminated to the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.** | **88%** |
| **8.2.4** | 1 | **The service asks patients and carers for feedback about their experiences of using the service and this is used to improve the service.** | **50%** |
| **8.2.5** | 2 | **Services are developed in partnership with appropriately experienced patient and carers who have an active role in decision making.** | **25%** |
| **8.2.6** | 2 | **There is a well-attended business meeting held within the team at least monthly in which information and learning can be disseminated, and the business of care on the ward can be discussed.** | **69%** |
| **8.2.7** | 2 | **The ward team use quality improvement methods to implement service improvements.** | **75%** |
| **8.2.8** | 2 | **The team actively encourages patients and carers to be involved in QI initiatives.** | **31%** |

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## QED Inpatient Member services:

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**Avalon ward**, South West London & St George's MH NHS Trust

**Avanti ward**, Priory Hospital Hayes Grove

**Bartle unit**, The Priory Hospital, Preston

**Birch ward**, Tees, Esk & Wear Valleys NHS Foundation Trust

**Cilantro Suite**, Birmingham and Solihull Mental Health NHS FT

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**Sunrise ward**, Cygnet Hospital Ealing

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**The Haldon**, Devon Partnership NHS Foundation Trust

**Tyson West 2**, South London and Maudsley NHS Foundation Trust

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Finally, a big thank you to all of our **QED Patient and Carer Representatives**, for the continuous support, dedication and insight.

# Get Involved!

## Join the network!

In order to register, you must provide a purchase order for the relevant membership fee and send a completed joining form. For all QED membership enquiries and for more information about joining the network, please contact qed@rcpsych.ac.uk.

## Benefits of Membership

**Quality Improvement**
Sharing of good practice, challenges and recommendations

**Events**
Members have discounted access (free if online) to in person Annual Forums, Special Interest Days, and webinars

**Networking**
Members can access Knowledge Hub, an interactive online discussion platform, and can meet peers on reviews across the UK

**Lived Experiences**
Involving our patient and carer representatives in QED is our priority. All resources are co-produced

**Resources & Publications**
We publish annual reports and share resources to member services, allowing national recommendations and benchmarking.