QED
QUALITY NETWORK FOR EATING DISORDERS

QED Inpatient Report 2021

Editors: George Mycock and Jessica Butler

Contents

Foreword

Hello everyone,

It gives me great pleasure to introduce the 2021 QED Inpatient report. We are still living through unprecedented times with so much additional pressure on services; the service users and their families that access them, as well as all staff working in our inpatient units who have had so many additional challenges to overcome in the workplace due to the pandemic.

This report is testament to everyone involved in the QED network regarding their hard work in not only managing your day-to-day work, but also finding time and having the commitment to contribute to the network through organising and preparing for reviews, providing evidence, participating in peer reviews, supporting our service users and carers to participate, collating information, report writing, attending college meetings... the list goes on!

I hope you will find this report a helpful resource in presenting some of the thematic analysis accrued over the past twelve months as well as suggesting some recommendations to help sustain and improve our services even more.

Paul Williams - QED Accreditation Committee Chair

Introduction

The Quality Network for Eating Disorders (QED) works with adult inpatient and community services to assure and improve the quality of services treating people with eating disorders and their carers.

Through a comprehensive process of review, we identify and acknowledge high standards of organisation and patient care, and support other services to achieve these.

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.

Inpatient reviews: 2019-2021

The data presented in this report covers 31 inpatient eating disorder service reviews (30 of which were finalised reports) which took place between January 2019 to July 2021. All services were reviewed against the QED 2nd Edition Inpatient Standards using a process of self-review, data collection through patient, carer, and staff questionnaires, a case note audit, and interviews with patients, carers, and frontline staff. Services also submitted evidence such as policies and proformas. Each service received a review by a multi-disciplinary peer review team, including a member of the QED project team and a patient or carer representative.

There was a lot of variety between services, for example, the breadth or diversity of their geographical coverage, the make-up of their staffing complement, and the interventions offered. This highlighted the importance of standardisation in order to ensure equality of access for patients, but also made apparent just how much our teams have to offer others in the way of experience and innovation.

Service locations

All inpatient eating disorder services within the UK are members of the QED network and therefore cover a wide spread of the UK (See Appendix 1).

2nd Edition Standards

The QED assess eating disorder services in accordance with a set of standards. The standards are drawn from a range 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.

Types of standard

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 excellent service should meet or are standards that are not the direct responsibility of the team. Accredited services must meet at least 60% of these.

Standards domains

The QED 2nd Edition Inpatient Standards are grouped into 5 domains:

1) General Standards
2) Timely and Purposeful Admission
3) Safety
4) Environment and Facilities
5) Therapies and Activities

Report Rationale

What to expect in this report:

The 2021 QED Inpatient report gives an overview of the adherence to the QED 2nd Edition Inpatient Standards fr om 31 inpatient services across the United Kingdom.

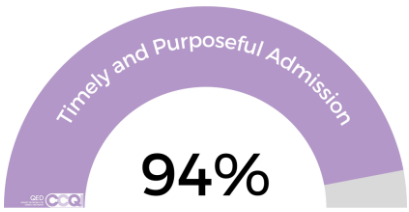
The QED team collated the data from all 31 accreditation reviews and carried out quantitative analysis to ascertain the overall compliance to the QED 2nd Edition Inpatient Standards. The standards are split into five subsections, the overall adherence (those marked as met or N/A) to these subsections are shown below.

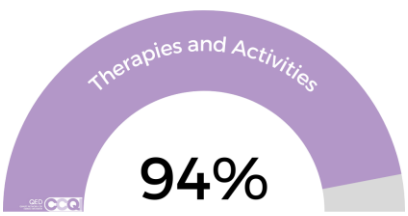
How to use the report:

This report can be utilised in many ways. To increase accessibility, the QED team undertook a thematic analysis of the unmet standards (See pp. 11 - 23). Each of these themes highlight keys areas that services can reflect on and target when looking to improve.

We have also highlighted the 3 most commonly unmet standards within each theme alongside recommendations for services struggling to meet them.

For those who wish to delve deeper, the compliance percentages for all standards are given in Appendix 2.





Contextual Data

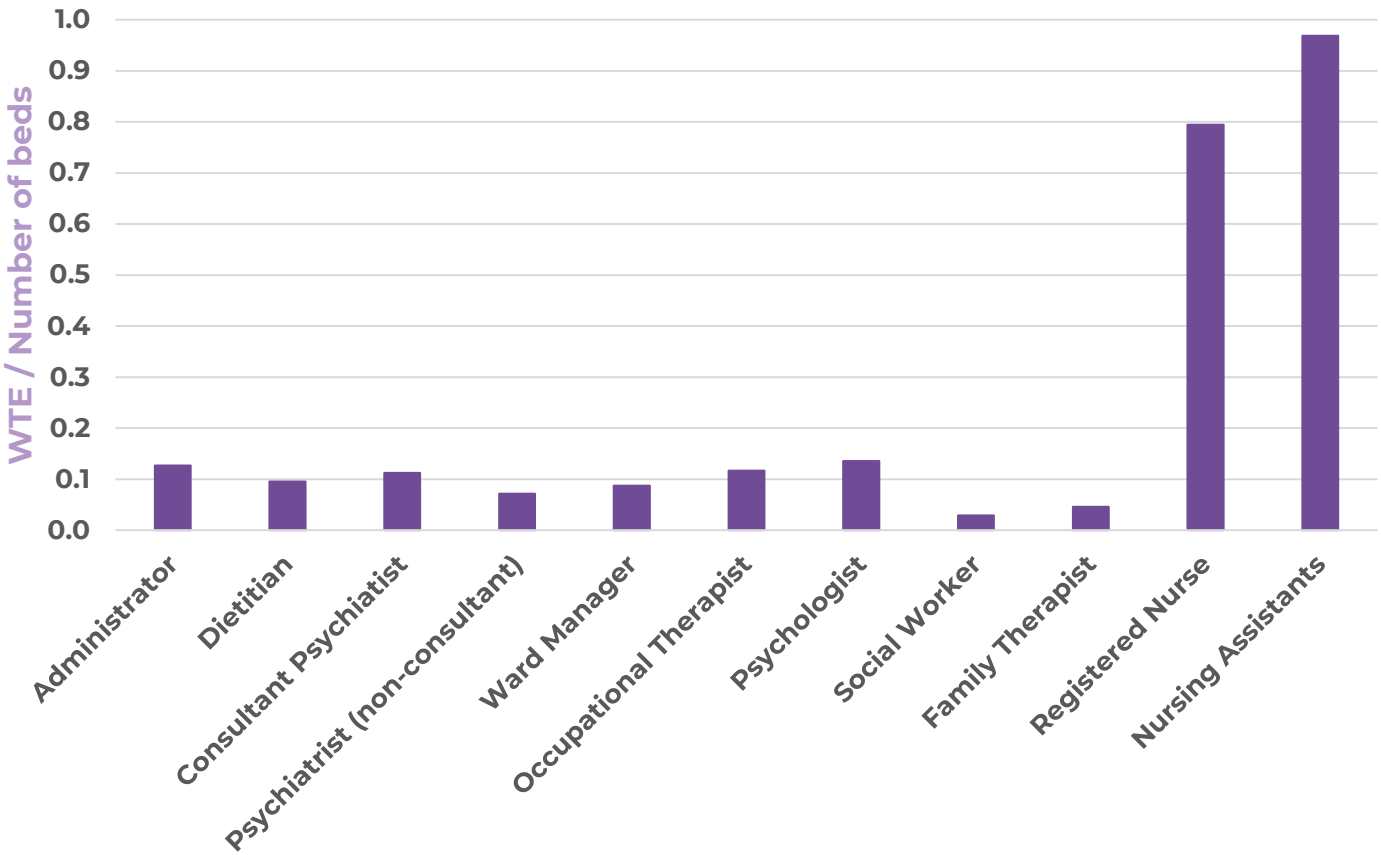
Data taken from the 31 inpatient services' self reviews:

The average number of beds is 13.4, ranging from 5 to 27 per service

The average length of stay for patients is 107 days, ranging from 42 to 208 days

87.1% of Inpatient wards report as mixed sex services

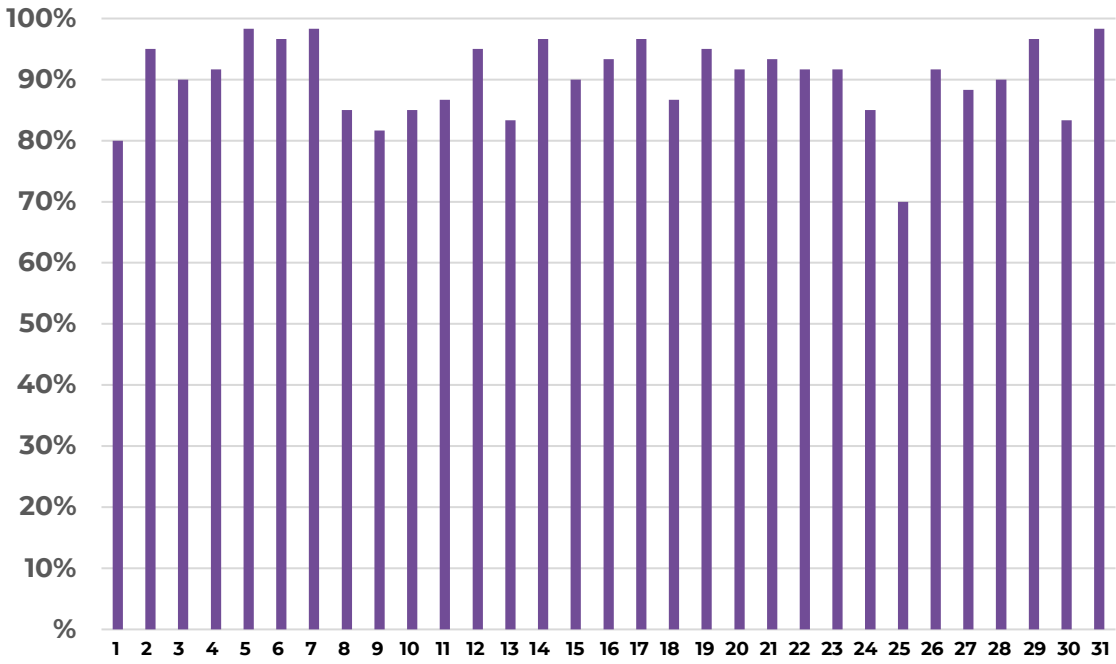
Average WTE of service occupations in relation to numbers of beds*



*Within each service, WTE for each occupation was divided by the number of beds. These results were collated from the 31 services and the averages are displayed.

Section 1: General Standards

Total Met Standards



*Each bar represents an inpatient service

Achievements

Across all services the average compliance with section 1 standards was 90%. 22 of 60 standards were met by all services.

100% of services actively support staff well-being. (1.2.4)

100% of services have a dedicated consultant psychiatrist. (1.3.1)

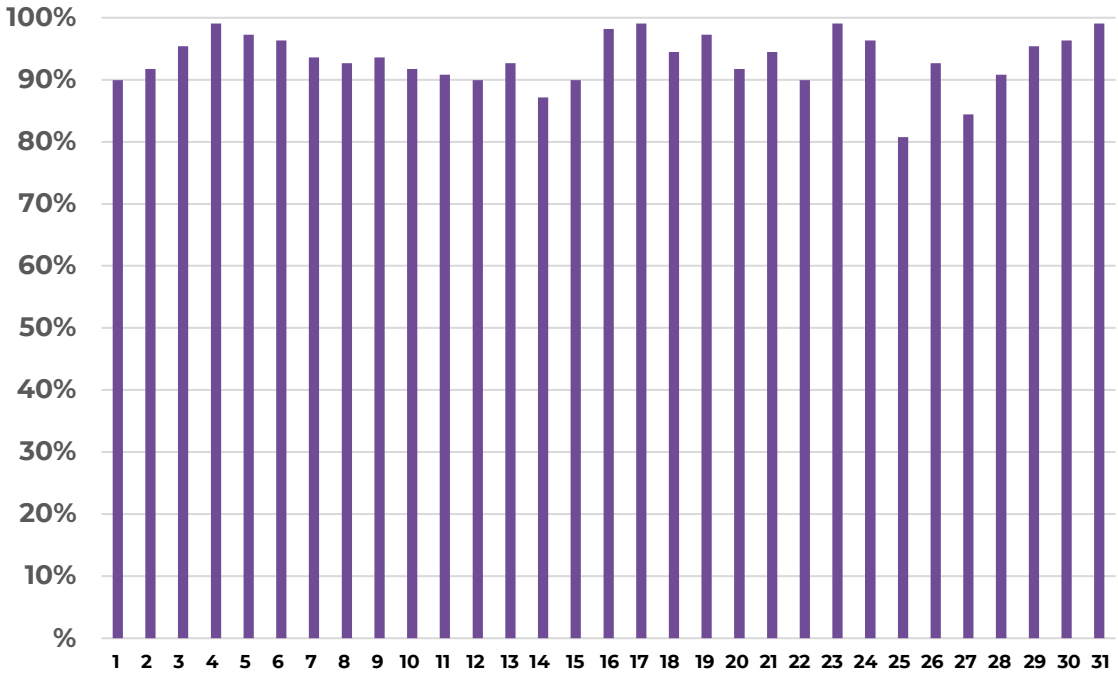
Improvements

Seven of the standards under this section were not met by over 30% (10) of the 31 services reviewed; three of which are type 1 standards.

Over half (55%) of the services were not involving patients or carers in the interviewing process for new staff members on the ward. (1.4.3)

Section 2: Timely and Purposeful Admission

Total Met Standards



*Each bar represents an inpatient service

Achievements

Across all services the average compliance with section 2 standards was 93%. 53 of 109 standards were met by all services.

100% of services show new patients around the ward when they are well enough to do so. (2.6.1)

100% of services explain the purpose of admission to patients. (2.6.12)

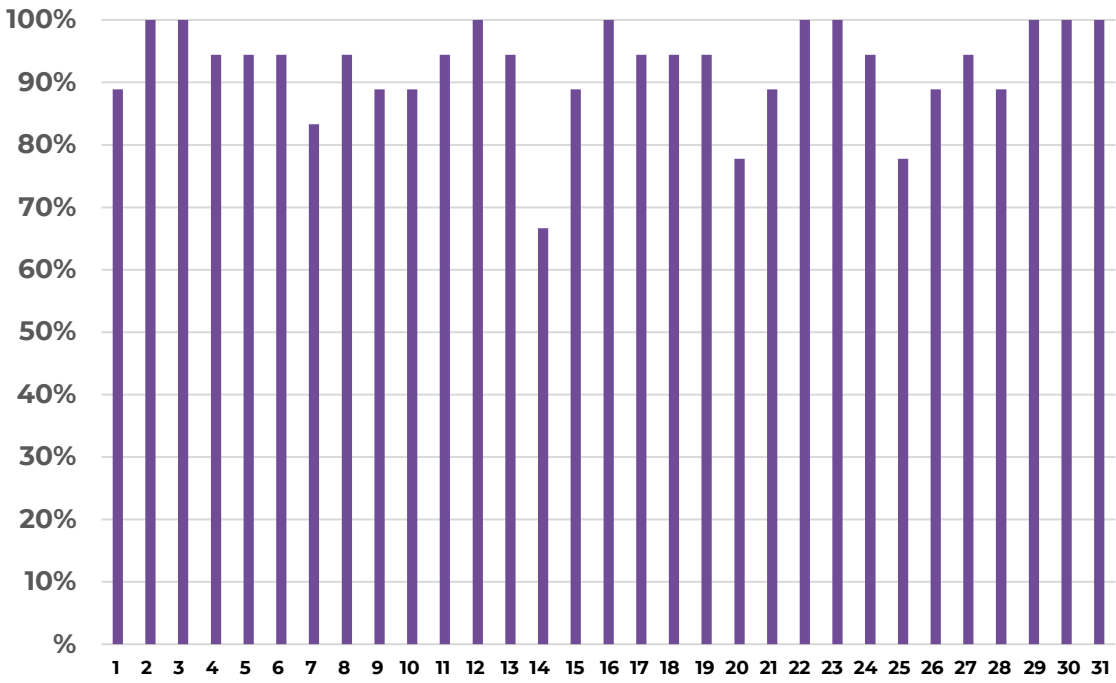
Improvements

Seven of the standards under this section were not met by over 25% (8) of the 31 services reviewed; four of which are type 1 standards.

Almost half (45%) of services did not advise family/carers on how to access a statutory carers' assessment provided by an appropriate agency. (2.10.3)

Section 3: Safety

Total Met Standards



*Each bar represents an inpatient service

Achievements

Across all services the average compliance with section 3 standards was 92%. 9 of 18 standards were met by all services.

***100%* of services have a system to enable staff to quickly and effectively report incidents. (3.3.5)**

***100%* of services have a collective response to alarms and fire drills. (3.3.11)**

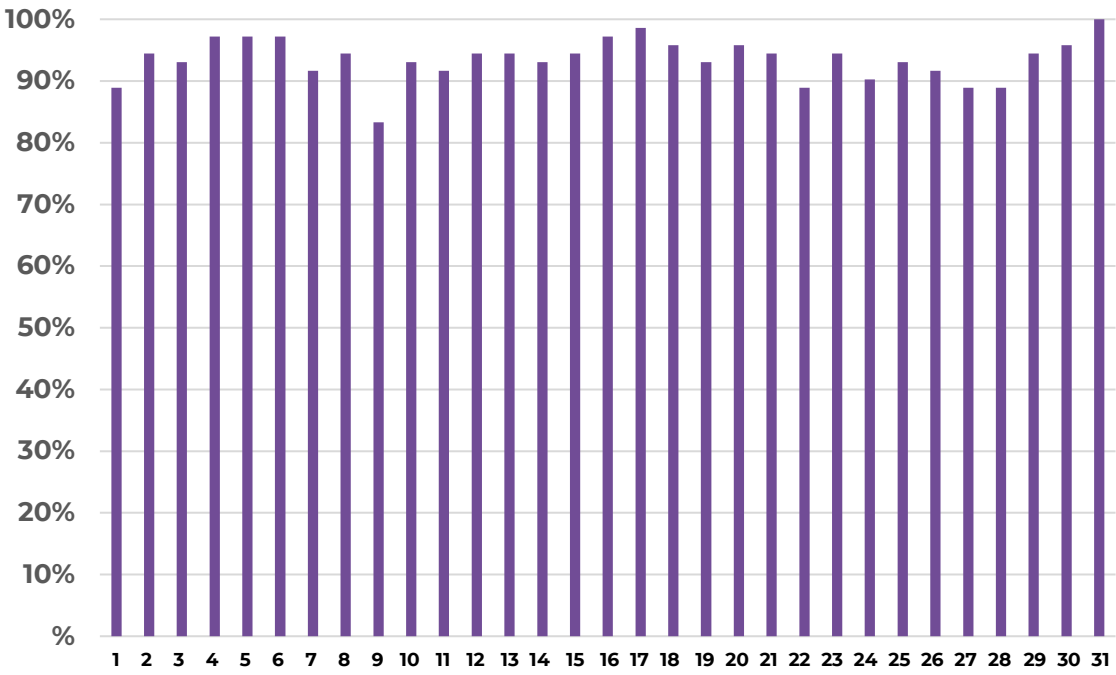
Improvements

Three of the standards under this section were not met by over 15% (5) of the 31 services reviewed; all of which are type 1 standards.

Over 15% of services did not routinely offer support and time to talk to patients who witnessed a distressing event, including episodes of control and restraint, and rapid tranquillisation. (3.3.10)

Section 4: Environment and Facilities

Total Met Standards



*Each bar represents an inpatient service

Achievements

Across all services the average compliance with section 4 standards was 94%. 32 of 72 standards were met by all services.

100% of services have assured patients are able to personalise their bedrooms. (4.6.14)

100% of services have assured access to a range of culturally-specific resources for entertainment. (4.11.1)

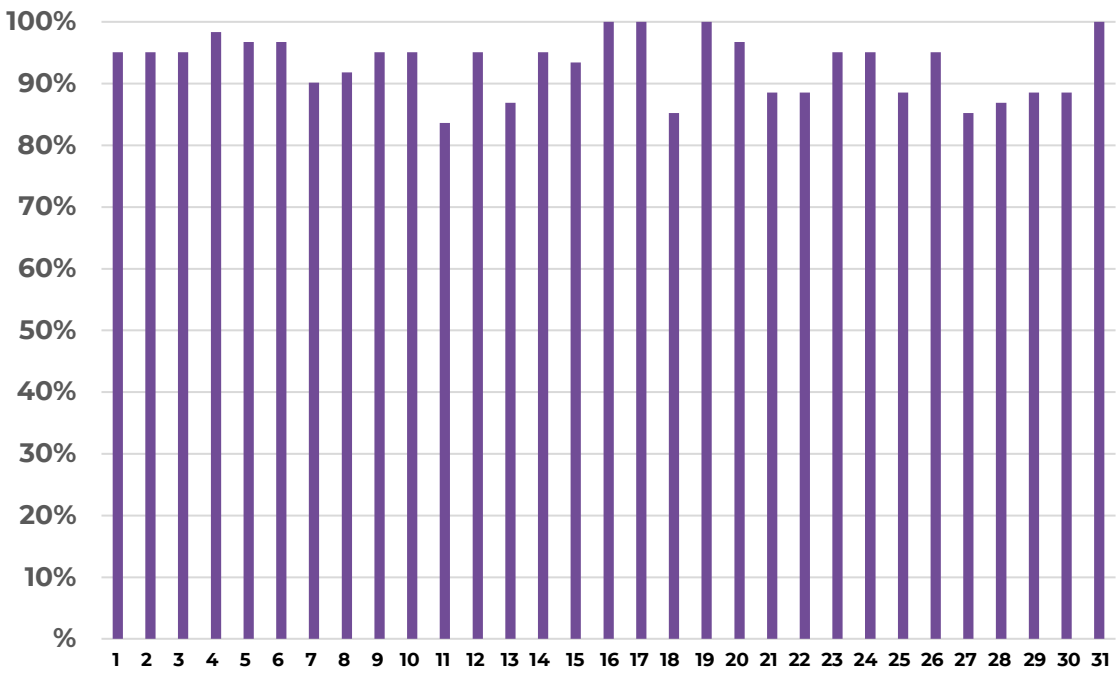
Improvements

Six of the standards under this section were unmet by over 25% (8) of the 31 services reviewed; although, none are type 1 standards.

Over a quarter (26%) of services did not have a designated space where patients receive visits from children, with appropriate facilities such as toys and books. (4.6.6)

Section 5: Therapies and Activities

Total Met Standards



*Each bar represents an inpatient service

Achievements

Across all services the average compliance with section 5 standards was 93%. 26 of 61 standards were met by all services.

100% of services treat their patient with compassion, dignity and respect. (5.3.1)

100% of services support patients to self-manage therapeutic leave. (5.8.2)

Improvements

Six of the standards under this section were unmet by over 25% (8) of the 31 services reviewed; one of which is a type 1 standard.

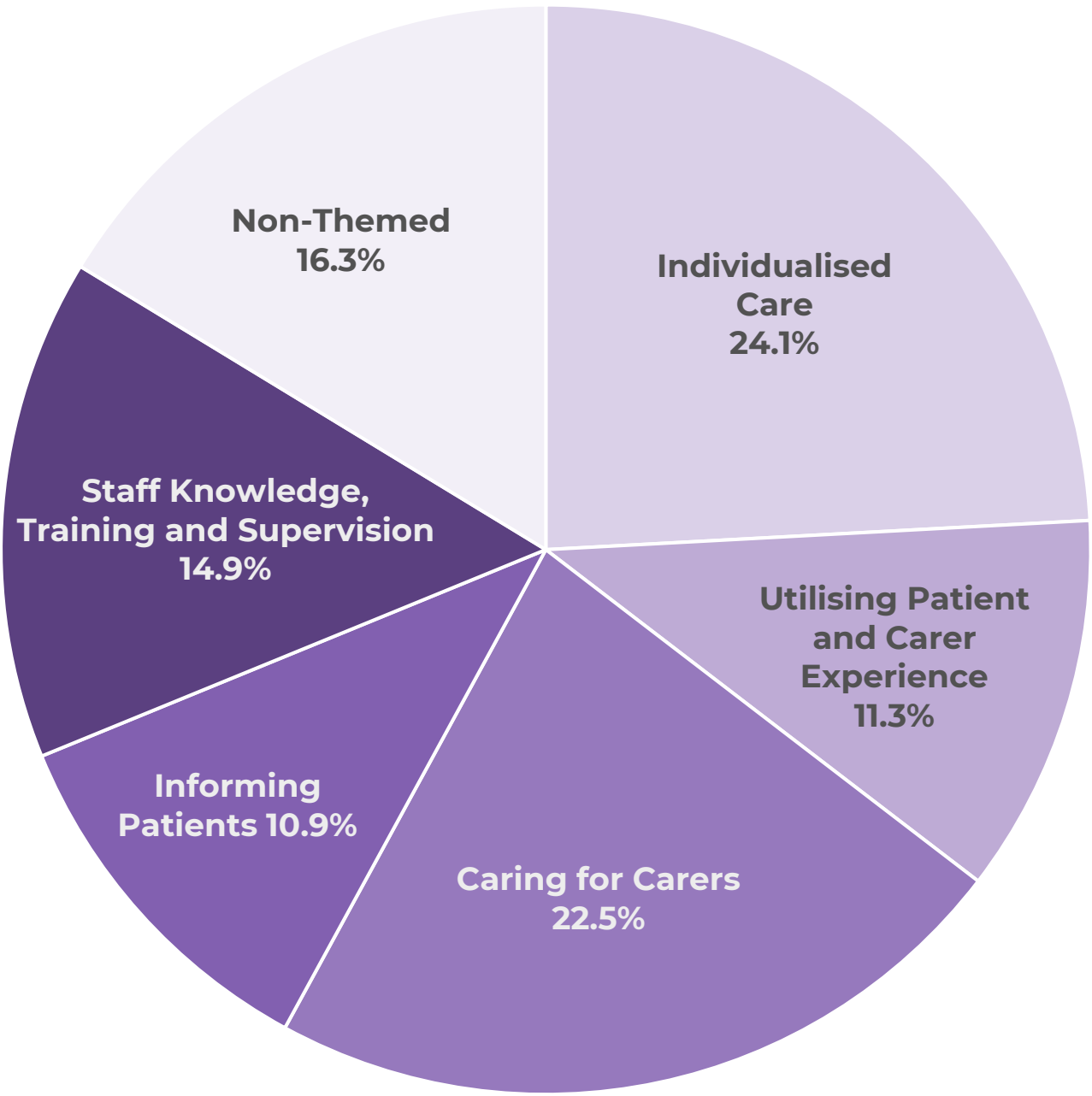
Almost half (42%) of services did not facilitate social and recreational activities at weekends that are tailored to patient's needs. (5.6.5)

Unmet Standards Thematic Analysis: Methods and Rationale

There were 602 total unmet standards across the 31 inpatient service accreditations. The thematic analysis process began with the collection of unmet standards (See full data set in Appendix 2), which were reduced down to only the frequently unmet standards (with 'frequently unmet standards' being defined as standards that were unmet by approximately 10% of services or more - 3 or more). The project team then grouped the standards into "themes" formulated from the standards description. The frequency of unmet standards within these themes were then quantitatively analysed using Microsoft Excel to understand the coverage of each theme and the most frequently unmet standards within them. These themes shed a light on the common aspects of an inpatient eating disorder service that do not meet the QED inpatient standards. The themes are:

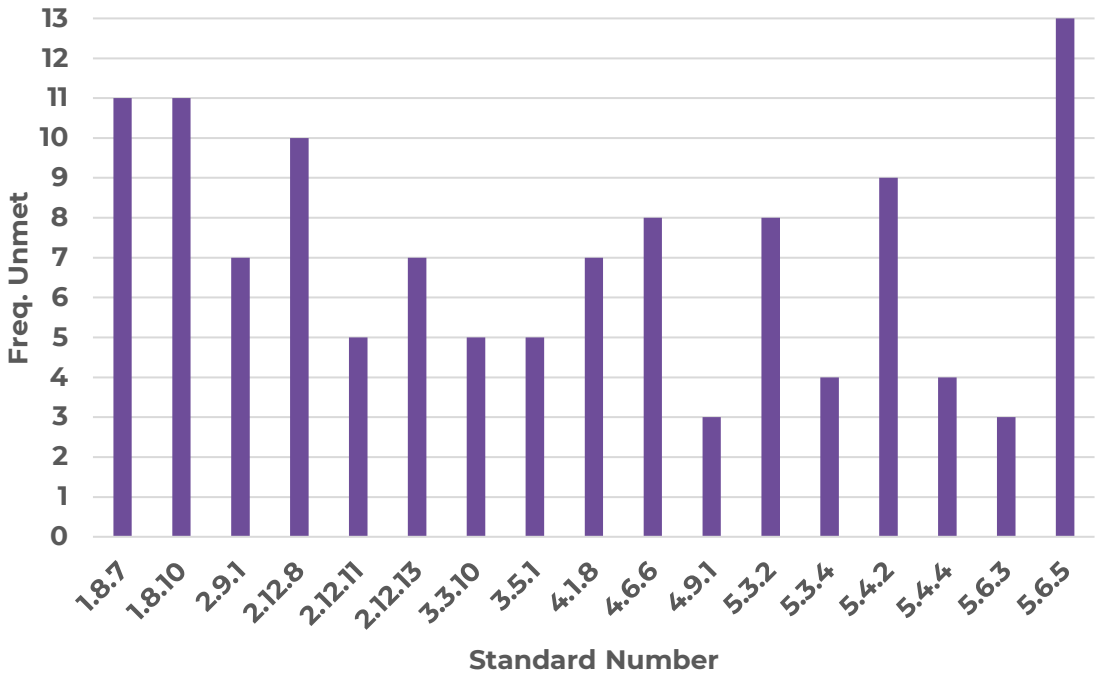
Individualised Care	**This theme relates to how services recognise and adapt care for each patient in line with their individual preferences and needs.**
Utilising Patient and Carer Experience	**The standards in this theme relate to how services use lived experience from their past and current patients/carers to impact their service.**
Caring for Carers	**This theme contains standards that relate to how a service supports families and/or partners of patients through various methods.**
Informing Patients	**This theme relates to providing patients with relevant information about their care and the options available to them within a timely manner.**
Staff Knowledge, Training and Supervision	**This theme contains standards which refer to the information, training and supervision provided to staff to help promote excellence and safety within the service.**

Unmet Standards Thematic Analysis: Overall Results



Theme 1: Individualised Care

Total Unmet Standards



Theme Description

This theme relates to how the service adapt care for each patient in line with their individual preferences and needs. From the thematic analysis we found that there were the most unmet standards within this theme (24.1%). It is important that services are vigilant of this issue, to ensure patients are not treated with 'blanket' protocols.

The Impact

Most of the standards within this theme are type 1. Services will need to ensure they meet all type 1 standards before receiving accreditation.

Services that don't prioritise individualised care for patients will impact overall wellbeing which is likely to have a negative impact on the process of recovery.

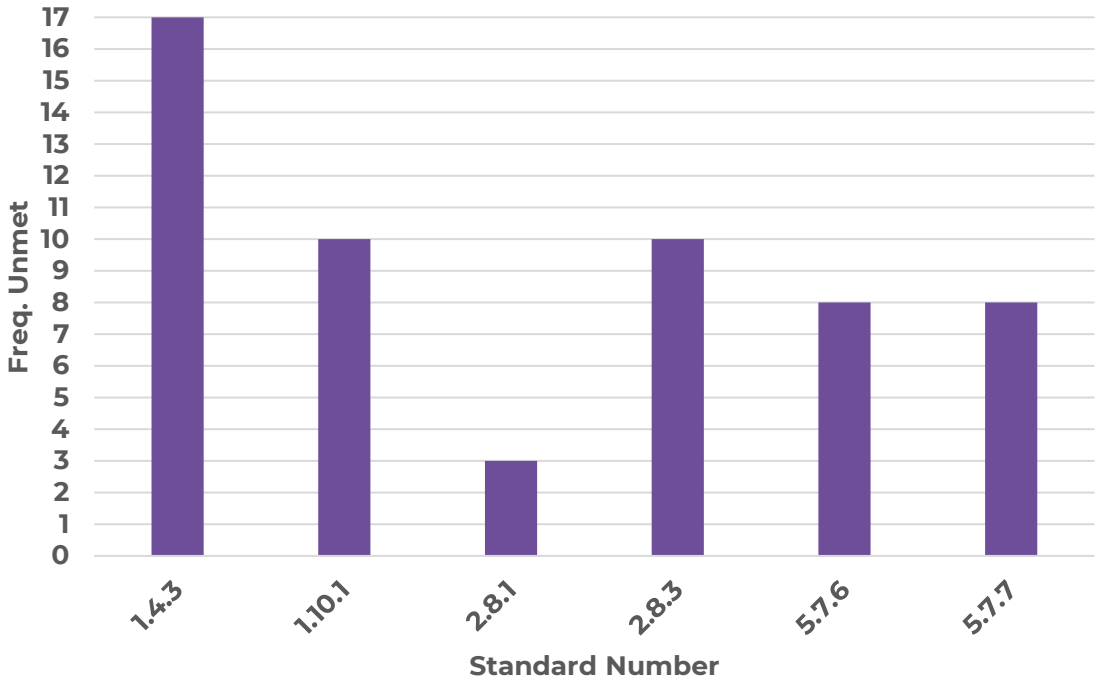
Theme 1: Individualised Care

Most commonly unmet standards

	Standard criteria	Recommendations
No.1 frequently unmet standard (5.6.5 – Type 1)	Staff facilitate social and recreational activities at weekends that are tailored to patient's needs.	To meet this standard, services should have a separate weekend timetable which is co-designed, alongside patients, and is facilitated by a member of staff.
No.2 frequently unmet standard (1.8.7 – Type 1)	Staff receive training in managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	Services should look to schedule training/ workshops that educate staff around these topics. Services have done this internally (if appropriately trained staff are available) as well as utilising external agencies.
No.3 frequently unmet standard (1.8.10 – Type 1)	Staff receive training in recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities	Services should aim to create content that is appropriate for patients with special needs. Services could create videos of information for those who may find reading information difficult. Services could also look to involve local learning disability organisations to help collaborate on improvements.

Theme 2: Utilising Patient and Carer Experience

Total Unmet Standards



Theme Description

This theme relates to how services use lived experience from their discharged and current patients and carers to improve or change their service. This theme comprises 11.3% of all unmet standards and can prove vital in creating the best patient and carer experience.

The Impact

Not adhering to the standards within this theme can often leave patients/carers feeling ignored and powerless over decisions.

Services that do not utilise lived experience may miss out on vital perspectives that go unseen and unheard without the input of experts by experience.

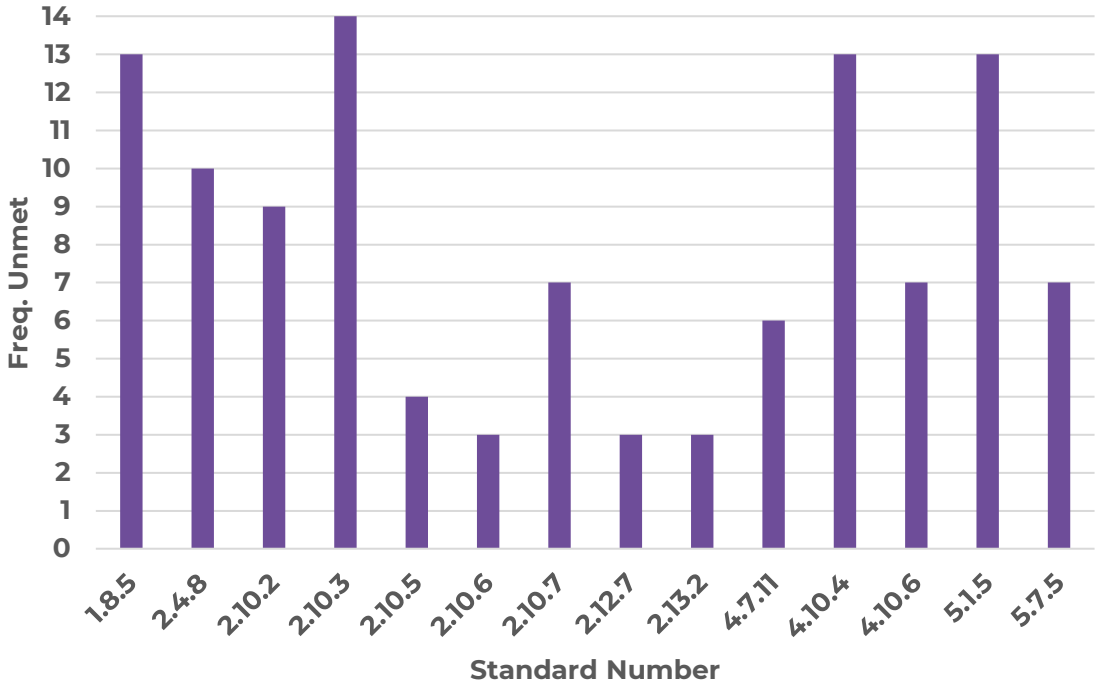
Theme 2: Utilising Patient and Carer Experience

Most commonly unmet standards

	Standard criteria	Recommendations
No.1 frequently unmet standard (1.4.3 – Type 2)	Patient or family/carer representatives are involved in interviewing potential staff members during the recruitment process.	Services could set up a patient and carer forum where interview questions can be submitted and designed. Patient and carers can also put themselves forward to be present at interviews using this.
No.2 frequently unmet standard (2.8.3 – Type 1)	Patients and their family/carers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service.	Services have previously introduced a "You said, we did" board that lists feedback from patients/carers alongside future plans to help address suggestions. Services should also look to proactively and clearly create opportunities for patient and carer feedback.
No.3 frequently unmet standard (1.10.1 – Type 1)	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.	This is often unmet due to a lack of carer involvement. Services should make sure to note if a patient has refused consent to send a copy of the care plan to carers. Services should also look to add the opportunity of review as part of their protocol.

Theme 3: Caring for Carers

Total Unmet Standards



Theme Description

This theme relates to how a service supports families and/or partners of patients. From the thematic analysis we found that there were the second most unmet standards within this theme (22.5%) This shows that carers can often be forgotten about. It is important services take care of those surrounding the patient, as the impact of eating disorders often spreads beyond the patient themselves.

The Impact

If carer experience is lacking, barriers will likely occur for patients transitioning out of the service. As carers are then suddenly responsible for their loved ones care.

Carers must be cared for to aid with the pressures of caring for their loved one. Carers can feel isolated and confused without help.
Recommendations to improve carer experience can be found on page 18.

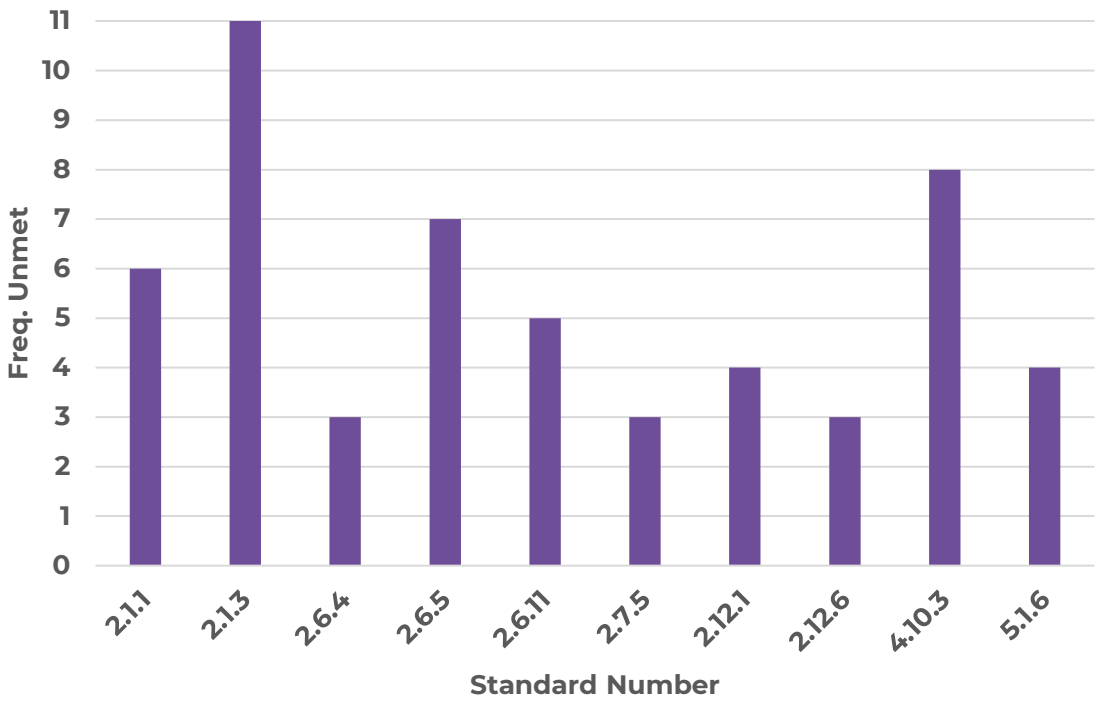
Theme 3: Caring for Carers

Most commonly unmet standards

	Standard criteria	Recommendations
No.1 frequently unmet standard (2.10.3 – Type 1)	Family/Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.	Services should look to include this information within carer information packs and/or within the protocol of first meetings with carers.
No.2 frequently unmet standard (4.10.4 – Type 2)	Staff receive training in: Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	Services should work diligently to improve the awareness of carer experience. Service could involve carers in the development of such training to help improve the way carers are treated, improving carer experience.
No.3 frequently unmet standard (1.8.5 – Type 2)	Patients and their family/carers are offered high quality information and harm minimisation advice about short and long-term risks (e.g. damage to teeth, reproductive system, osteoporosis) and this is recorded.	Services should, at minimum, include this information within their carer welcome pack. Often the carer will be the one responsible for looking after the patient once they leave the inpatient service so it is vital they have an understanding of the risks. This should help reduce the likelihood of the patient relapsing.

Theme 4: Informing Patients

Total Unmet Standards



Theme Description

This theme relates to providing patients with relevant information about their care and the options available to them within a timely manner. This is the least common of the identified themes (10.9%) but is just as important. Failing to meet these standards can mean patients are uninformed about their own treatment and the decisions they are able to make.

The Impact

These standards carry an ethical weight, as services who do not adhere to them may leave patients in the dark about important aspects of care.

It is important services strive to keep patients informed about changes to care and opportunities around them to ensure the patient is treated fairly and ethically.

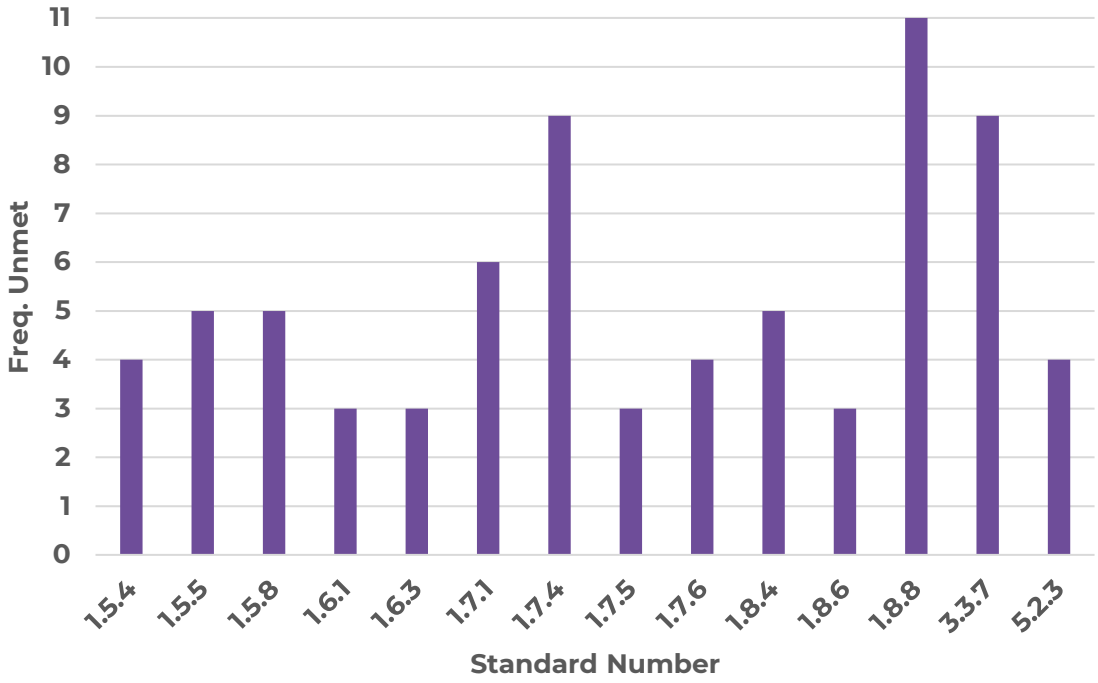
Theme 4: Informing Patients

Most commonly unmet standards

	Standard criteria	Recommendations
No.1 frequently unmet standard (2.1.3 – Type 2)	The patient is informed of the process of how and when they may access their current records if they wish to do so.	This should be added to the welcome pack/handbook given to patient when they first arrive at the service.
No.2 frequently unmet standard (4.10.3 – Type 2)	Patients and, where appropriate, family/carers, are offered education and information on the nature, course and treatment of eating disorders.	Patients should be informed about their care, the options available to them, and their illness, as much as possible to reduce any confusion surrounding care. Services should make information available via leaflets and links.
No.3 frequently unmet standard (2.6.5 – Type 1)	Patients are given verbal and written information on: • Their rights regarding consent to care and treatment • How to access advocacy services • How to access a second opinion • How to access interpreting services • How to raise concerns, complaints and compliments • How to access their own health records This information is visible on the ward.	This information should be added to patient welcome packs. Services have previously described a “checklist” used during initial assessment, where the staff member will go through each of these and check them off as thy go. Print outs of this information should then be assigned to a notice board and/or in leaflets on the ward for patients to access at any point.

Theme 5: Staff Knowledge, Training and Supervision

Total Unmet Standards



Theme Description

This theme relates to the information, training and supervision provided to staff to help promote excellence and safety within the service. This theme contains the third most frequently unmet standards (14.9%). Adherence to these standards will result in improved care as well as improved staff and patient experience.

The Impact

Providing inadequate training and supervision for staff may affect morale within the service as well as care.

Making sure staff are properly training and frequently assessed is vital to producing quality care and reducing the likelihood and frequency of mistakes.

Theme 5: Staff Knowledge, Training and Supervision

Most commonly unmet standards

	Standard criteria	Recommendations
No.1 frequently unmet standard (1.8.8 – Type 2)	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity.	Services should look to provide relevant reading materials in staff rooms and on computers. Staff should also be encouraged to have weekly time for research where possible.
No.2 frequently unmet standard (1.7.4 – Type 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.	It is important that staff are appropriately trained in eating disorder care in order to treat eating disorder patients. This training should be added to the induction process for all staff. Services should be able to clearly evidence that training contains the listed contents.
No.3 frequently unmet standard (3.3.7 – Type 1)	Staff members know how often patients are restrained and how this compares to benchmarks, e.g. by participating in multi-centre audits or by referring to their previous years' data.	Services should audit this periodically and this should be shared within staff meetings along with comparisons to multi-centre audits/previous reports.

Thematic Analysis Conclusion

Overall the QED member services did well to adhere to the QED 2nd Edition Inpatient Standards, with the lowest adherence to a section of the standards being 92% (pp.4).

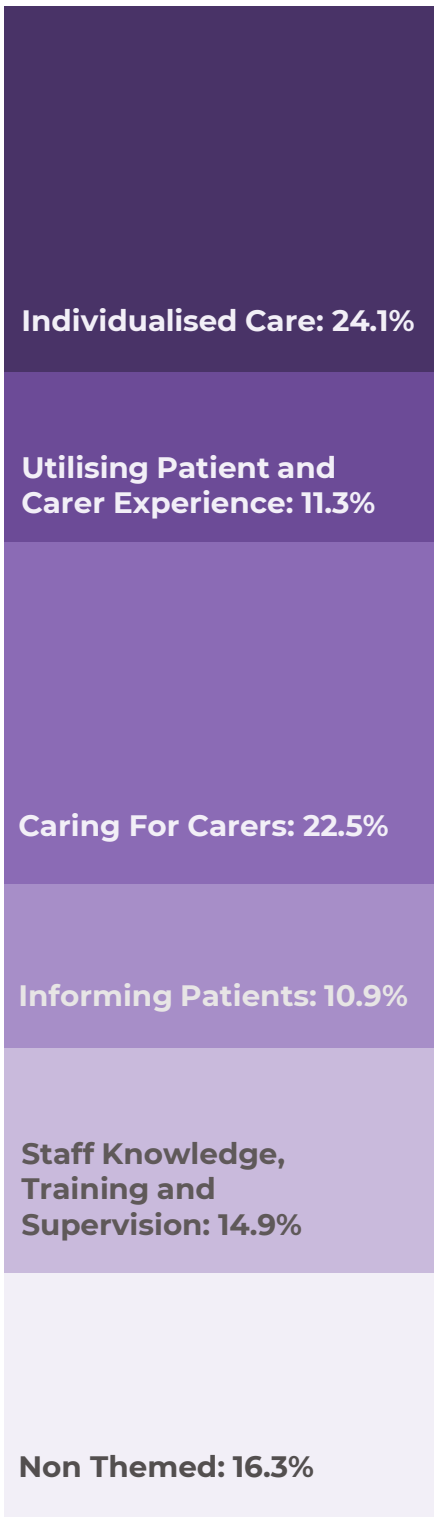
The five themes suggested from thematic analysis have hopefully shone a light on the areas that inpatient eating disorder services frequently require improvement.

Four of the five themes are surrounding the way patient and carers are treated, with the most common of all being "Individualised care". These issues can be due to a host of problems, including the affect of the COVID pandemic which has seen a rise in referrals and a restriction surrounding aspects of care.

Services should look to create an inclusive, compassionate and individual experience for all patients and carers referred to their ward. The last of the themes relates to staff on the ward which again may have been impacted by COVID as the 'usual' way of delivering training face to face had to suddenly change.

The QED team hope that services can take pride in their adherence rates to the overall standards and aim to do the same at their upcoming reviews. We also hope services can utilise the thematic analysis to guide future adaptations to protocol and implementation of care they provide.

Percentage of the 602 unmet standards covered by each theme



3rd Edition Inpatient Standards

Both the inpatient and community standards are reviewed every two years to improve the standards validity and accessibility. In February 2021 we published the QED 3rd Edition Inpatient Standards aft er revision of the 2nd Edition Inpatient Standards.

During the revision, we brought together staff from the Royal College of Psychiatrists, from eight of the services within the QED network, and the QED Advisory group, which includes people from a variety of occupations as well as patient/carer representatives. This group submitted comments on the 2nd Edition Inpatient Standards and then attended a workshop to discuss changes to be implemented.

New Sections

One of the main changes to the 3rd Edition Inpatient Standards is the creation of new domains to help create clearer distinctions between standards. The 8 new domains are:

1. Access and Admission
2. Environment and Facilities
3. Staffing and Training
4. Care and Treatment
5. Information, Consent and Confidentiality
6. Rights and Safeguarding
7. Discharge
8. Clinical Governance

Other Changes

Other changes include rewording of standards to specify more clearly the expectations of services, to make standards more relevant to inpatient eating disorder services, to add guidance for services regarding standards, and to reduce the overall number of standards by combining related standards.

Example Change

Standard 2.4.8 – "Patients and their families/carers are invited to visit the ward/unit prior to admission."

This standard has now been updated with the guidance: "This may be achieved virtually, e.g. through a video tour."

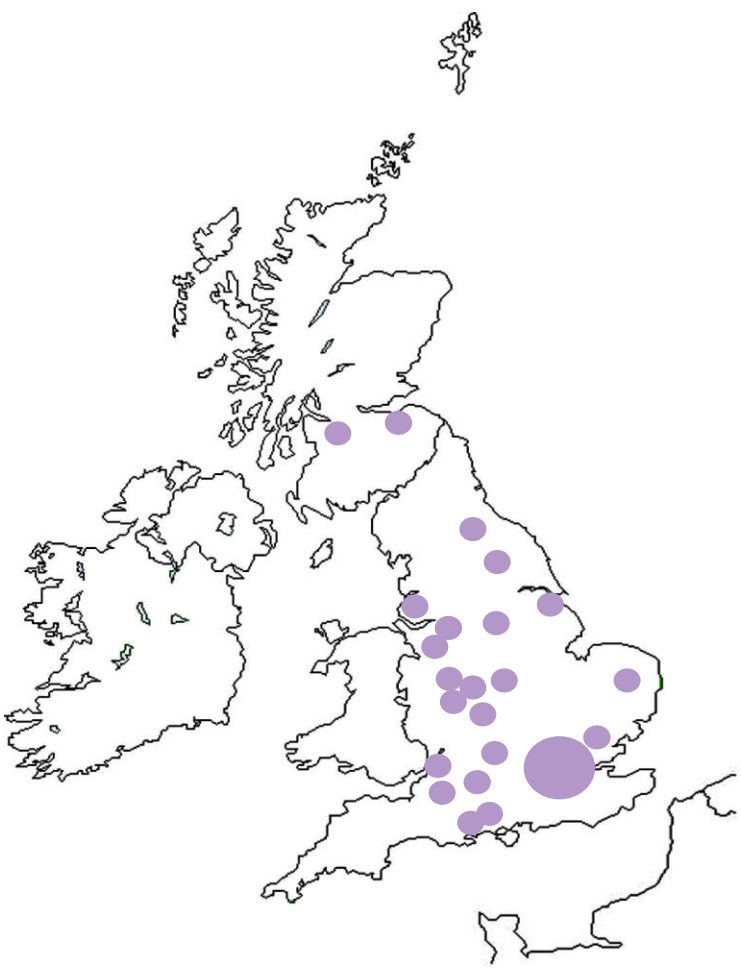
Appendix 1: List of services involved

- Avon and Wiltshire Mental Health Partnership NHS Trust - STEPS Unit
- Barnet, Enfield and Haringey Mental Health NHS Trust - Iris Ward
- Birmingham and Solihull Mental Health NHS FT - Cilantro Suite
- Central and North West London NHS FT - Vincent Square
- Cheshire and Wirral Partnership NHS FT - Oaktrees
- Coventry and Warwickshire Partnership NHS Trust - Aspen Centre
- Dorset HealthCare University NHS FT - Kimmeridge Court
- Groupe Sinoue, Nightingale Hospital - ED Unit
- Leeds Partnership NHS FT - Newsam Centre, Ward 6
- Leicestershire Partnership NHS Trust- Langley Ward
- NAViGO - Rharian Fields
- Newmarket House Clinic
- NHS Lothian - Regional Eating Disorder Unit
- Northumberland, Tyne and Wear NHS Foundation Trust - Richardson ED Service, Ward 31A
- Oxford Health NHS FT - Cotswold House, Marlborough
- Oxford Health NHS FT - Cotswold House, Oxford
- Priory Cheadle Royal - Russell House
- Priory Hospital Bristol - Lotus Ward
- Priory Hospital Chelmsford - Springfield Ward
- Priory Hospital Glasgow - Coll Ward
- Priory Hospital Hayes Grove - ED Unit
- Priory Hospital Preston - Bartle Unit
- Priory Hospital Roehampton

Appendix 1: List of services involved

- Priory Hospital Southampton - Skylark Ward
- Priory Woodbourne - Oak Ward
- Riverdale Grange Limited
- Schoen Clinic York - Naomi Unit
- South London and Maudsley NHS FT - Tyson West Two
- South Staffordshire and Shropshire Healthcare NHS FT – Kinver Ward
- South West London and St George's Mental Health NHS Trust - Avalon Ward
- Tees, Esk and Wear Valleys NHS Foundation Trust - Birch Ward

The order presented does not correlate with the numbers displayed on figures (pp. 8-12)



Appendix 2: All standards data

1		Section 1 General Standards	Percentage met
1.1		Policies And Protocols	
1.1.1	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%
1.1.2	2	Front-line staff members are involved in key decisions about the service provided.	94%
1.2		Staffing Levels	
1.2.1	1	The ward/unit adheres to agreed minimum staffing levels that comply with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	97%
1.2.2	2	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the ward/unit.	100%
1.2.3	1	The ward/unit has a mechanism for responding to low staffing levels, including: - A method for the team to report concerns about staffing levels - Access to additional staff members - An agreed contingency plan, such as the minor and temporary reduction of non-essential services	97%
1.2.4	1	The ward/unit actively supports staff health and well-being.	100%
1.2.5	2	The ward/unit is staffed by permanent staff members, and bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need.	90%
1.3		MDT Staff	
1.3.1	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 overall service co-ordination.	100%
1.3.2	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 a psychiatric emergency - Attend the ward/unit within 1 hour during normal working hours - Attend the ward/unit within 4 hours when out of hours	97%
1.3.3	2	The ward/unit has input from a dietitian	100%

1.4		Recruitment And Retention Of Staff	
1.4.1	2	If the ward/unit uses bank and agency staff members, the service manager monitors their use on a monthly basis. An overdependence on bank and agency staff members results in action being taken.	100%
1.4.2	1	The ward/unit actively supports staff health and well-being.	100%
1.4.3	2	Patient or family/carer representatives are involved in interviewing potential staff members during the recruitment process.	45%
1.5		Appraisal, Supervision And Staff Support	
1.5.1	1	All staff members receive an annual appraisal and personal development planning (or equivalent).	100%
1.5.2	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.	94%
1.5.3	2	The quality and frequency of clinical supervision is monitored quarterly by the clinical director (or equivalent).	100%
1.5.4	2	All supervisors have received specific training to provide supervision. This training is refreshed in line with local guidance.	87%
1.5.5	2	All staff members receive monthly line management supervision.	84%
1.5.6	2	Staff members have access to reflective practice groups.	90%
1.5.7	1	Staff members are able to take breaks during their shift that comply with Working Time Regulations.	100%
1.5.8	2	Staff members in training and newly qualified staff members are offered weekly supervision.	74%
1.6		Staff Induction	
1.6.1	1	All newly qualified staff members are allocated a preceptor to oversee their transition onto the ward/unit. All new staff members are allocated a mentor to oversee their transition onto the ward/unit.	90%
1.6.2	1	All staff, including temporary/agency staff, have a comprehensive induction to the service, which covers key aspects of care.	94%
1.6.3	1	Staff members receive an induction programme specific to the ward/unit that covers: - The purpose of the ward/unit - The teams clinical approach - The roles and responsibilities of staff members - The importance of family and carers - Care pathways with other services.	90%

1.7		Staff Education And Training	
1.7.1	1	All staff members who administer medications have been assessed as competent to do so. Assessment is repeated on a yearly basis using a competency-based tool.	77%
1.7.2	2	Staff members can access leadership and management training appropriate to their role and specialty.	97%
1.7.3	1	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: Statutory and mandatory training	94%
1.7.4	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.	71%
1.7.5	1	Staff delivering individual family and group therapies for adults with eating disorders are trained and supervised to do so.	87%
1.7.6	2	Staff who are involved in supporting patients' mealtimes have been trained in meal and post-meal support.	87%
1.7.7	2	The Ward/Unit provides training, supervision and support for a dietitian.	100%
1.7.8	1	When restraint is required to support NG feeding, it is delivered by staff who are trained in appropriate restraint techniques.	74%
1.8.1	2	Care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning.	97%
1.8.2	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent)	97%
1.8.3	1	The team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on: - Safeguarding vulnerable adults and children - Assessing and managing suicide risk and self-harm - Prevention and management of aggression and violence.	94%
1.8.4	2	Clinical outcome measures	81%
1.8.5	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	58%
1.8.6	1	Physical health assessment	90%
1.8.7	1	Managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	65%
1.8.8	2	Staff members have access to study facilities (including books and journals on site or online) and time to support relevant research and academic activity.	65%
1.8.9	1	Clinical staff members have received formal training to perform as a competent practitioner, or, if still in training, are practising under the supervision of a senior qualified clinician.	97%

1.8.10	1	Recognising and communicating with patients with special needs, e.g. cognitive impairment or learning disabilities	52%
1.9		Advocacy	
1.9.1	1	The ward/unit has a working relationship with a range of advocacy services that includes the IMCA service.	100%
1.1		Compliments And Complaints	
1.10.1	1	Patients and their family/carers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service.	68%
1.11		Reporting Inappropriate/Abusive Care	
1.11.1	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.	100%
1.12		Smoking	
1.12.1	2	Where smoking is permitted, there is a safe allocated area for this purpose.	61%
1.13		Leadership And Culture	
1.13.1	1	There are written documents that specify professional, organisational and line management responsibilities.	100%
1.13.2	2	Staff members have an understanding of group dynamics and of what makes a therapeutic environment.	100%
1.13.3	3	The organisation’s leaders provide opportunities for positive relationships to develop between everyone.	100%
1.13.4	1	Staff members and patients feel confident to contribute to and safely challenge decisions.	100%
1.13.5	1	Staff members feel able to raise any concerns they may have about standards of care.	100%
1.14		Teamworking	
1.14.1	2	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises.	100%
1.14.2	2	The team has protected time for team-building and discussing service development at least once a year.	97%

1.15		General Management	
1.15.1	2	The team attends business meetings that are held at least monthly.	97%
1.15.2	3	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.	97%
1.16		The Ward/Unit Learns From Complaints And Serious Incidents	
1.16.1	1	Staff members share information about any serious untoward incidents involving a patient with the patient themselves and their family/carer, in line with the Duty of Candour agreement.	100%
1.16.2	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisation.	100%
1.16.3	2	Key clinical/service measures and reports are shared between the team and the organisation's board, e.g. findings from serious incident investigations and examples of innovative practice.	100%
1.17		Commissioning And Financial Management	
1.17.1	2	The ward/unit is explicitly commissioned or contracted against agreed ward/unit standards.	97%
1.17.2	3	Commissioners and service managers meet at least 6 monthly.	94%
2		**Section 2 Timely And Purposeful Admission**	
2.1		Timely And Purposeful Admission	
2.1.1	1	Confidentiality and its limits are explained to the patient and family/carer on admission, both verbally and in writing.	81%
2.1.2	2	The patient is involved, wherever possible, in decisions about when, where and with whom information about them is going to be shared and used. Where they are not involved in decisions, there is a clear policy in place for managing this	97%
2.1.3	2	The patient is informed of the process of how and when they may access their current records if they wish to do so.	65%
2.1.4	1	The team has integrated patient records used by all staff.	100%
2.1.5	2	Information and guidance about the specialist service, including timescales from referral to admission and written referral criteria, is readily available to referrers.	100%
2.1.6	2	The admission policy describes how decisions regarding the appropriate place of admission for older people are primarily based on mental and physical need.	71%
2.1.7a	1	Consultant responsibility	94%
2.1.7b	1	The roles and responsibilities of inpatient and community teams in both eating disorder and other services	97%
2.1.7c	1	The requirement for joint care planning at an individual level	94%

2.1.7d	1	The requirement for a written care plan to specify what support each service can expect from the other	90%
2.1.7e	1	Roles and responsibilities in relation to CPA	97%
2.1.7f	1	Information-sharing	97%
2.1.8	1	The ward/unit has access to specialist services to treat co-morbid conditions, and staff are aware of how to access these services	100%
2.2		Control Of Bed Occupancy	
2.2.1	1	There is a clear process in place for handling situations where agreed bed occupancy levels need to be exceeded.	58%
2.2.2	1	Senior clinical staff members make decisions about patient admission or transfer. They can refuse to accept patients if they fear that the mix will compromise safety and/or therapeutic activity	100%
2.3		Leave	
2.3.1	1	The team develops a leave plan jointly 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	97%
2.3.2	1	Staff members follow a lone working policy and feel safe when escorting patients on leave.	100%
2.3.3	1	Patients are only sent on leave by mutual agreement with their carers, and timely contact with them beforehand, where appropriate	94%
2.3.4	1	The team follows a protocol for managing situations where patients are absent without leave.	100%
2.4		Referrals	
2.4.1	1	Admission is provided when physical health is severely compromised and admission is needed for medical stabilisation and initiation of refeeding and cannot be achieved by outpatient care.	100%
2.4.2	1	The Unit/Ward does not use single measures of BMI or the duration of the patients illness to determine whether to offer treatment	100%
2.4.3	1	A designated member of the team, with appropriate eating disorder experience, reviews all referrals and assigns priority within two working days of receipt.	100%
2.4.4	2	The service provides an initial verbal response to referrers within two working days of receipt of a written referral and this is documented.	100%
2.4.5	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.	94%
2.4.6	2	A formal written report follows within 14 days of assessment with the service.	84%

2.4.7	1	In the case of non-attendance, the ward/unit contacts the referrer immediately to ascertain the patient's level of risk.	100%
2.4.8	2	Patients and their families/carers are invited to visit the ward/unit prior to admission.	65%
2.5		On Or Before Admission	
2.5.1	1	There is an identified and documented contact or link person for each agency involved with each patient.	100%
2.5.2	2	All community assessment documentation is available to the admitting team before the patient arrives on the ward/unit, including mental health and current risk assessments and stated purpose of admission.	100%
2.5.3	1	Inpatient units have a protocol for prioritising admissions of those with needs that are of high risk, and for those in need of Early Intervention in order to minimise the risk of untreated illness.	100%
2.6		Admission Process	
2.6.1	1	On admission to the ward/unit, or when the patient is well enough, staff members show the patient around.	100%
2.6.2	1	On admission to the ward/unit staff members introduce themselves and other patients.	100%
2.6.3	1	When talking to patients and their families/carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them.	100%
2.6.4	1	The patient is given a welcome pack or introductory information that contains the following: - A clear description of the aims of the ward/unit - The current programme and modes of treatment - The ward/unit team membership - Personal safety on the ward/unit - The code of conduct on the ward/unit - Ward/unit facilities and the layout of the ward/unit - What practical items can and cannot be brought in - Clear guidance on the smoking policy in smoke-free hospitals and how to access smoking breaks off the hospital grounds - Resources to meet spiritual, cultural and gender needs	90%
2.6.5	1	Patients are given verbal and written information on: - Their rights regarding consent to care and treatment - How to access advocacy services - How to access a second opinion - How to access interpreting services - How to raise concerns, complaints and compliments - How to access their own health records This information is visible on the ward.	77%
2.6.6	1	Detained patients are given verbal and written information on their rights under the Mental Health Act (or equivalent) and this is documented in their notes.	94%
2.6.7	1	On the day of their admission or as soon as they are well enough, the patient (and their family/carer, where permitted) is told the name(s) of their Primary Nurse/care team and how to arrange to meet with them.	94%

2.6.8	1	Where a patient is being admitted directly from the community, the admitting nurse checks that the referring agency gives clear details on and management plans for: - The security of the patient's home - Arrangements for dependents (children, people they are caring for) - Arrangements for pets	100%
2.6.9	1	Staff members address patients using the name and title they prefer.	100%
2.6.10	1	Staff members are easily identifiable (for example, by wearing appropriate identification).	100%
2.6.11	2	Staff members explain the main points of the welcome pack to the patient and ask if they need further information on anything explained.	84%
2.6.12	1	Staff members explain the purpose of the admission to the patient.	100%
2.6.13	1	All patients have a documented diagnosis and a clinical formulation.	97%
2.6.14	1	Admissions are not extended for psychological therapy alone.	97%
2.7		Initial Assessment	
2.7.1	1	Patients have a comprehensive physical health review. This is started within 4 hours of admission and is completed within 1 week, or prior to discharge. It includes: <u>First 4 hours</u> - Details of past medical history - Current medication, including side effects and compliance (information is sought from the patient history and collateral information within the first 4 hours. Further details can be sought from medical reconciliation after this) - Physical observations including blood pressure, heart rate and respiratory rate <u>First 24 hours</u> - Physical examination - Height, weight - Blood tests (Can use recent blood tests if appropriate) - ECG <u>First 1 week</u> - Details of past family medical history - A review of physical health symptoms and a targeted systems review - Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use	100%
2.7.2	1	Patients are offered a staff member of the same gender as them, and/or a chaperone of the same gender, for physical examinations. The ward/unit has a protocol relating to this.	94%
2.7.3	1	Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission.	100%
2.7.4a	1	Clearly documented in their records	94%
2.7.4b	1	Regularly reviewed	94%
2.7.4c	1	Communicated to all MDT members	94%
2.7.4d	1	Evaluated with them and, where appropriate, their carer/advocate	94%

2.7.5	1	Patients are informed of the outcome of their physical health assessment and this is recorded in their notes.	84%
2.7.6	1	The patient has the option to involve the people they rely on for support (carers/relatives/neighbours/friends) in their assessment.	100%
2.7.7	1	Patients have a comprehensive assessment which is started within 4 hours and completed within 1 week. This involves the multi-disciplinary team and includes patients': - Mental health and medication - Psychosocial needs - Goals for treatment	100%
2.7.8	1	Patients have an assessment of their capacity to consent to admission, care and treatment within 24 hours of admission.	100%
2.7.9	1	A formal assessment of nutritional status is carried out by a qualified dietitian on admission, within two working days.	100%
2.7.10	1	All patients with an eating disorder are offered individualised dietetic interventions from a qualified dietitian, alongside the MDT, to assess nutritional status, prescribe individualised eating plans and support behaviour change around food.	100%
2.7.11	1	If a patient is identified as at risk of absconding, the team completes a crisis plan, which includes clear instructions for alerting and communicating with their family/ carers, people at risk and the relevant authorities.	100%
2.8		Care Planning	
2.8.1	1	Within 7 days of the patients admission a care plan has been jointly developed with the community team, the patient and the family/carers that includes a discharge plan (with the patients consent)	90%
2.8.2	1	Nutritional needs are identified in the care plan on admission.	100%
2.8.3	1	The patient and their carer (with patient consent) are offered a copy of the care plan and the opportunity to review this.	68%
2.8.4	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	100%
2.9		Management Of Risk	
2.9.1	1	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.	77%
2.9.2	1	Patients have a risk assessment that is shared with relevant agencies (with consideration of confidentiality) and includes a comprehensive assessment of: - Risk to self - Risk to others - Risk from others - Risk of refeeding syndrome and compensatory behaviours	97%
2.1		Family/Carers	
2.10.1	1	The patient's main family/carers are identified and contact details are recorded.	100%
2.10.2	1	Family/Carers are contacted within 48 hours of the patients admission and offered the opportunity to discuss concerns, family history and their own needs.	71%
2.10.3	1	Family/Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.	55%
2.10.4	1	The team follows a protocol for responding to family/carers when the patient does not consent to their involvement.	100%

2.10.5	2	Family/Carers have access to a carer support network or group. This could be provided by the ward/unit or the team could signpost carers to an existing network.	87%
2.10.6	2	The ward/unit has a designated staff member dedicated to family/carer support (carer lead).	90%
2.10.7	1	The team provides each family/carer with a carers information pack.	77%
2.11		Continuous Assessment	
2.11.1	2	If needs are identified that cannot be met by the ward/unit team, then a referral is made to a service that can. The referral is made within a specified time period after identifying the need, and the date of the referral is recorded in the patient's notes.	97%
2.11.2	2	Where an unmet need is identified there is a clear mechanism for reporting it.	100%
2.11.3	1	Capacity assessments are performed in accordance with current legislation.	100%
2.11.4	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%
2.12		Reviews And Management Of Treatment	
2.12.1	1	Patients are facilitated and supported to prepare for any formal review of their care (CPA or equivalent)	87%
2.12.2	1	Full MDT clinical review meetings occur at least once a week.	100%
2.12.3	1	Multidisciplinary team (MDT) members introduce themselves to the patient and their family/carer at every MDT review where they are present.	100%
2.12.4	1	Patients and their family/carers are able to contribute and express their views during formal reviews (CPA or equivalent).	97%
2.12.5	2	An appropriate representative from involved agencies is invited to attend the first review.	100%
2.12.6	1	Actions from reviews are fed back to the patient (and their family/carer, with the patients consent) and this is documented.	90%
2.12.7	2	Lead clinicians are available for ad hoc meetings with patients and their family/carers when these are requested.	90%
2.12.8	1	The team reviews and updates care plans with the patient, family and community team within 4 weeks and then monthly going forward. This is to review the need for ongoing inpatient treatment and the effectiveness of treatment plans	68%
2.12.9	1	There is a documented CPA review meeting within the first six weeks of admission.	100%
2.12.10	1	There is a documented admission meeting within one week of the patients admission.	100%
2.12.11	1	The patient and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis or treatment.	84%
2.12.12	2	The ward/unit provides written feedback to referrers a minimum of once every eight weeks.	90%

2.12.13	3	Patients are supported to lead their own care review.	77%
2.12.14	1	Risk assessments and management plans are updated according to clinical need and Trust Guidelines, or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	100%
2.12.15	1	The team reviews and updates care plans according to clinical need and Trust guidelines, or at a minimum frequency that complies with College Centre for Quality Improvement specialist standards.	100%
2.13		Discharge Planning	
2.13.1	2	Managers and practitioners have agreed standards for transfer/discharge planning.	100%
2.13.2	1	Patients and their family/carer (with patient consent) are involved in decisions about discharge plans and are invited to a discharge meeting.	90%
2.13.3	2	The patient is given timely notification of transfer or discharge and this is documented in their notes.	100%
2.13.4	1	The clinical decision to discharge should not be based on BMI or clinical risk alone, and must balance effectiveness, benefits and risk of ongoing admission and discharge	100%
2.13.5	1	Written information setting out a clear discharge plan, which the patient takes home with them, is sent to all relevant parties before or on the day of discharge. The plan includes details of: - Care in the community/aftercare arrangements - Risk and contingency arrangements including details of who to contact - Medication - Details of when, where and who will follow up with the patient	97%
2.13.6	1	The team follows a protocol to manage informal patients who discharge themselves against medical advice. This includes: - Recording the patient's capacity to understand the risks of self-discharge - Putting a crisis plan in place - Contacting relevant agencies to notify them of the discharge	100%
2.13.7	2	Where there are delayed transfers/discharges: - The team can easily raise concerns about delays to senior management - Local information systems produce accurate and reliable data about delays - Action is taken to address any identified problems	100%
2.13.8	2	Discharge planning is initiated at the first multi-disciplinary team review and a provisional discharge date is set.	87%
2.13.9	2	Discharge planning includes relapse prevention planning, and a relapse prevention plan is included with the CPA documentation.	90%
2.13.10	1	There are transfer protocols in place to transfer patients into acute medical services and these comply with MARSIPAN recommendations.	94%
2.13.11	2	If a patient requires transfer to another ward/unit (e.g. medical/psychiatric etc.), the eating disorder service ensures that nutritional support and psychosocial interventions are maintained and are MARSIPAN-compliant.	100%
2.13.12	1	When patients are transferred between wards/units there is a handover which ensures that the new team have an up to date care plan and risk assessment.	100%

2.13.13	1	The team makes sure that patients who are discharged from hospital to the care of the community team have arrangements in place to be followed up within one week of discharge, or within 48 hours of discharge if they are at risk.	100%
2.13.14	2	Patients have supported periods of home leave to develop independent eating, well in advance of discharge.	100%
2.14		Interface With Other Services	
2.14.1	2	There are joint working protocols/care pathways in place to support patients in accessing the following services: - Accident and emergency - Social services - Local and specialist mental health services e.g. liaison, eating disorders, rehabilitation - Secondary physical healthcare	94%
2.14.2	2	The team supports patients to access organisations which offer: - Housing support - Support with finances, benefits and debt management	97%
2.14.3	3	The ward/unit has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice.	74%
2.15		Capacity And Consent	
2.15.1	1	When patients lack capacity to consent to interventions, decisions are made in their best interests.	97%
2.15.2	1	There are systems in place to ensure that the ward/unit takes account of any advance directives that the patient has made.	100%
3		**Section 3 Safety**	
3.1		Safety	
3.1.1	1	There is a daily handover between the nursing staff, doctors and other relevant members of the MDT.	100%
3.1.2	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	100%
3.1.3	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed, in line with Trust/organisational policy.	90%
3.2		Observation	
3.2.1	1	Patients are told about the level of observation that they are under, how it is instigated, the review process and how their own patient perspectives are taken into account.	94%
3.3		Management Of Violence	
3.3.1	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 a psychiatric emergency - Attend the ward/unit within 1 hour during normal working hours - Attend the ward/unit within 4 hours when out of hours	100%
3.3.2	1	Staff members follow a protocol when conducting searches of patients and their personal property.	100%
3.3.3	1	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	97%
3.3.4	1	The team audits the use of restrictive practice, including face-down restraint.	84%

3.3.5	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	100%
3.3.6	1	The team effectively manages patient violence and aggression.	100%
3.3.7	1	Staff members know how often patients are restrained and how this compares to benchmarks, e.g. by participating in multi-centre audits or by referring to their previous years' data.	61%
3.3.8	1	Repeated restraint of a patient is reviewed and a second opinion is sought and recorded.	90%
3.3.9	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team spends time with the patient reflecting on why this was necessary. The patient's views are sought and they are offered the opportunity to document this in their care record along with any disagreement with healthcare professionals.	90%
3.3.10	1	After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, the team makes sure that other patients on the ward/unit who are distressed by these events are offered support and time to discuss their experiences.	74%
3.3.11	1	A collective response to alarm calls and fire drills is agreed by the team before incidents occur. This is rehearsed at least 6 monthly.	100%
3.4		Pressure Ulcer Care	
3.4.1	1	There is a policy on the assessment and management of pressure sores.	100%
3.5		Management Of Alcohol And Illegal Drugs	
3.5.1	1	The ward/unit has a policy for the care of patients with dual diagnosis that includes: - Liaison and shared protocols between mental health and substance misuse services to enable joint working - Drug/alcohol screening to support decisions about care/treatment options - Liaison between mental health, statutory and voluntary agencies - Staff training - Access to evidence based treatments - Considering the impact on other patients of adverse behaviours due to alcohol/drug abuse	84%
3.5.2	2	Ward/unit managers and senior managers promote positive risk-taking to encourage patient recovery and personal development.	100%
4		**Section 4 Environment And Facilities**	
4.1		Environment And Facilities	
4.1.1	2	The ward/unit entrance and key clinical areas are clearly signposted.	97%
4.1.2	2	All patients have single bedrooms.	97%
4.1.3	2	The ward/unit has at least one bathroom/shower room for every three patients.	90%
4.1.4	3	Every patient has an en suite bathroom.	61%
4.1.5	2	All patients can access a charge point for electronic devices such as mobile phones.	100%

4.1.6	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)	94%
4.1.7	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.	97%
4.1.8	2	There are facilities for patients to make their own hot and cold drinks.	77%
4.1.9	3	Patients are informed about changes to the ward/unit environment.	94%
4.2		Safety	
4.2.1	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety and promoting recovery.	100%
4.2.2	1	Measures are put in place to ensure a safe environment is maintained through individual risk assessment and observations.	100%
4.2.3	1	Facilities ensure routes of safe entry to and exit from the ward/unit in the event of an emergency related to disturbed/violent behaviour.	100%
4.2.4	2	There is secure, lockable access to a patient's room, with external staff override.	90%
4.2.5	1	Furniture is arranged so that doors, in rooms where consultations take place, are not obstructed.	100%
4.2.6	1	An audit of environmental risk is conducted annually and a risk management strategy is agreed, in line with Trust/organisational policy.	97%
4.2.7	2	Doors have viewing panels or observation windows and their use is managed to balance privacy and safety.	81%
4.3		Alarm Systems	
4.3.1	1	There is an alarm system in place (e.g. panic buttons) and this is easily accessible.	100%
4.3.2	2	Where risks are identified, alarm systems/call buttons/personal alarms are available to patients and visitors, and instructions are given for their use.	97%
4.3.3	2	Alarm systems/call buttons/personal alarms are checked and serviced regularly.	100%
4.4		Medical Equipment	
4.4.1	1	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes.	100%
4.4.2	1	The crash bag is maintained and checked weekly, and after each use.	100%
4.4.3	2	The ward/unit has a designated room for physical examination and minor medical procedures.	97%
4.4.4	1	Hypostop or equivalent is available on the ward/unit, with guidance on its safe use.	100%

4.5		Confidentiality	
4.5.1	1	All patient information is kept in accordance with current legislation.	97%
4.5.2	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%
4.6		Use Of Rooms And Space	
4.6.1	1	All fixtures, fittings and equipment are in a good state of repair.	100%
4.6.2	1	All rooms are kept clean.	100%
4.6.3	2	Areas which need to be quiet are located as far away as possible from any sources of unavoidable noise.	100%
4.6.4	2	There is at least one room for interviewing and meeting with individual patients and relatives, which is furnished with comfortable seating.	97%
4.6.5	2	The ward/unit is managed to allow optimum use of available space and rooms.	100%
4.6.6	2	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys, books.	74%
4.6.7	2	There is a designated area or room (de-escalation space) that the team may consider using, with the patient's agreement, specifically for the purpose of reducing arousal and/or agitation.	61%
4.6.8	1	Male and female patients (self-defined by the patient) have separate bedrooms, toilets and washing facilities.	90%
4.6.9	1	The ward/unit environment is sufficiently flexible to allow for specific individual needs in relation to ethnicity.	100%
4.6.11	2	The ward/unit has at least one quiet room other than patient bedrooms.	97%
4.6.12	2	There are lounge areas that may become single-sex areas as required.	90%
4.6.13	2	Social spaces are located to provide views into external areas.	97%
4.6.14	2	Patients are able to personalise their bedroom spaces.	100%
4.6.15	3	The specialist service can signpost to nearby facilities for their family/carers to stay overnight when appropriate, and can advise on available funding.	90%
4.7		Catering	
4.7.1	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.	97%
4.7.2	1	The ward/unit has a designated dining area, which is reserved for dining only during allocated mealtimes.	100%
4.7.3	1	Staff members ask patients for feedback about the food and this is acted upon.	97%
4.7.4	1	The ward/unit has a written policy for how patients are therapeutically supported at mealtimes. This policy includes guidance around staff eating with patients.	94%
4.7.5	1	A dietitian oversees the catering provision to ensure the individual nutritional needs of the patients are being met.	100%

4.7.6	3	The food is freshly cooked on the hospital premises, rather than being reheated.	71%
4.7.7	1	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	100%
4.7.8	1	Ward/unit staff provide post-meal/snack support to patients, appropriate to the individual's care plan.	94%
4.7.9	1	Within a clearly described menu plan, food choices of patients are respected, as per the individual's care plan.	100%
4.7.10	2	Where menu choices have been restricted as part of treatment, there is a clear plan for reintroducing choice and encouraging patients to improve their relationship with food in a recovery-focused way.	97%
4.7.11	2	Where possible, family/carers are involved in the independent eating programme. For those who cannot be involved, individual feedback is given (with patient consent) or information is provided.	81%
4.7.12	1	Religious and ethical dietary restrictions are respected unless they present a threat to recovery.	100%
4.8		Dignity	
4.8.1	1	Patients can wash and use the toilet in private.	100%
4.8.2	1	Patients with poor personal hygiene have a care plan that reflects their personal care needs.	94%
4.8.3	1	Staff members respect the patient's personal space, e.g. by knocking and waiting before entering their bedroom.	100%
4.8.4	1	Patients can make and receive telephone calls in private.	100%
4.8.5	1	Staff members follow a policy on managing patients' use of cameras, mobile phones and other electronic equipment, to support the privacy and dignity of all patients on the ward/unit.	97%
4.8.6	2	Laundry facilities are available to all patients.	100%
4.8.7	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.	100%
4.8.8	1	The environment complies with current legislation on disabled access.	100%
4.9		Patient Comfort	
4.9.1	2	Staff members and patients can control heating, ventilation and light.	90%
4.1		Provision Of Information	
4.10.1	1	The ward/unit actively supports staff health and well-being.	100%
4.10.2	1	Information, which is accessible and easy to understand, is provided to patients and their family/carers.	100%
4.10.3	2	Patients and, where appropriate, family/carers, are offered education and information on the nature, course and treatment of eating disorders.	74%

4.10.4	2	Patients and their family/carers are offered high quality information and harm minimisation advice about short and long-term risks (e.g. damage to teeth, reproductive system, osteoporosis) and this is recorded.	58%
4.10.5	2	There is a clear strategy/protocol for addressing social networking concerns.	90%
4.10.6	1	Patients and their family/carers are offered written and verbal information about the patient’s mental illness.	77%
4.10.7	1	The ward/unit has access to interpreters and the patients relatives are not used in this role unless there are exceptional circumstances.	100%
4.10.8	2	The ward/unit uses interpreters who are sufficiently knowledgeable about mental health and skilled in the role to provide a full and accurate translation.	100%
4.11		Activity Equipment	
4.11.1	2	All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/units population.	100%
4.12		Outside Space	
4.12.1	2	The ward/unit has direct access to an outside space, which is safe and has seating.	97%
4.13		Staff Facilities	
4.13.1	2	Ward/unit-based staff members have access to a dedicated staff room.	87%
4.13.2	2	All staff have access to a locker or locked area to store personal belongings.	87%
5		**Section 5 Therapies And Activities**	
5.1		Medication	
5.1.1	2	During the administration or supply of medicines to patients, privacy, dignity and confidentiality are ensured.	100%
5.1.2	1	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.	97%
5.1.3	1	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, side effects and adherence to medication regime.	97%
5.1.4	2	Patients have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	97%
5.1.5	3	Family/Carers have access to a specialised pharmacist and/or pharmacy technician to discuss medications.	52%
5.1.6	1	Patients and their family/carers (with patient consent) are helped to understand the functions, expected outcomes, limitations and side effects of their medications and to self-manage as far as possible.	87%
5.1.7	2	Care is taken to ensure that medications and nutritional supplements are consistent with the patient's religious or cultural practices.	100%

5.1.8	1	When prescribing medication, prescribers take into account the impact of malnutrition and compensatory behaviours on effectiveness and the impact of the eating disorder on adherence.	100%
5.1.9	1	When medication is prescribed, specific treatment targets are set for the patient, the risks and benefits are reviewed, a timescale for response is set and patient consent is recorded.	97%
5.1.10	1	The team follows a policy when prescribing PRN (i.e. as required) medication.	100%
5.1.11	1	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	100%
5.1.12	1	The safe use of high risk medication is audited, at least annually and at a service level.	100%
5.2		Refeeding	
5.2.1	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.	97%
5.2.2	1	Staff implementing enteral feeding are trained in the physical and psychological aspects of its use.	84%
5.2.3	1	Staff implementing enteral feeding are assessed a minimum of annually as competent to do so.	74%
5.2.4a	1	Refeeding syndrome;	100%
5.2.4b	1	Electrolyte disturbance;	100%
5.2.4c	1	Extreme agitation;	100%
5.2.4d	1	Hypoglycaemia.	100%
5.2.5	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	100%
5.2.6	1	The patient is referred for treatment for on a medical ward/unit if they need treatment that is unavailable on the specialist eating disorder ward/unit.	100%
5.2.7	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%
5.2.8	1	Restraint to feed and/or nasogastric bridles should 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.	87%
5.2.9	1	Patients in the early stages of refeeding are monitored closely for signs of biochemical, cardiovascular and fluid balance disturbance.	100%
5.2.10	1	Goals around weight restoration targets (i.e. rate and amount of gain) are individually planned according to patient need.	100%
5.2.11	1	When restraint is required to support NG feeding, it is delivered by staff who are trained in appropriate restraint techniques.	87%

5.3		Engagement	
5.3.1	1	Patients are treated with compassion, dignity and respect.	100%
5.3.2	2	Each patient receives an arranged 1-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.	74%
5.3.3	1	Patients feel listened to and understood in consultations with staff members.	97%
5.3.4	1	There are cover arrangements in place for when patients are unable to meet with their keyworkers	87%
5.4		Staffing	
5.4.1	2	During the delivery of the formal therapeutic programme, there is at least one member of staff in each group and activity, and others available if needed.	100%
5.4.2	3	Patients have access to complementary therapies, in accordance with local policy and procedures.	68%
5.4.3	2	Staff are given planned and protected time to ensure activities and interventions are provided regularly and routinely.	97%
5.4.4	2	Staff facilitate a broad range of therapeutic and leisure activities both on and off the ward/unit.	87%
5.5		Therapeutic Milieu	
5.5.1	2	A weekly minuted patient meeting takes place that is attended by patients and staff members.	97%
5.6		Provision Of Activities And Therapies	
5.6.1	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	94%
5.6.2	1	Patients' preferences are taken into account during the selection of therapies and activities, and are acted upon as far as possible.	94%
5.6.3	2	Systems are in place to regularly review with patients and staff the quality and provision of group therapeutic and social activities.	90%
5.6.4	2	The frequency, regularity and diversity of activities is monitored.	100%
5.6.5	1	Staff facilitate social and recreational activities at weekends that are tailored to patient's needs.	58%
5.6.6	1	Ward therapeutic programmes reflect/promote a normal healthy balance of productivity (9-5), self-care and leisure and rest during evenings and at weekends.	87%
5.6.7	1	Patients are offered the following interventions, informed by the evidence base: - medication - individual psychological therapies - group therapies - family interventions and carer support	97%
5.6.8	1	The structured therapeutic programme focuses on eating behaviour and attitudes to weight and shape, and wider psychosocial issues. This includes self- care skills, work or study skills, leisure skills and life skills, and promotes independent living, communication, assertion and emotional coping.	97%
5.6.9	1	There is a structured therapeutic programme from Monday to Friday and the timetable is made available to patients.	94%
5.6.10	2	The content of the structured therapeutic programme includes time for meals and post-meal support, group and individual sessions and time made for leisure time. Meals and post-meal support are facilitated by staff.	97%

5.6.11	2	The content of the group programme includes a range of therapeutic models, including psychoeducation, psychological groups, occupational therapy groups and structured rest time.	97%
5.6.12	2	The patient's therapeutic programme is tailored and personalised to their individual needs and is supported by a timetable	97%
5.7		Group Activities And Therapies	
5.7.1	2	The MDT work to support a group philosophy and support patients to attend groups.	100%
5.7.2	3	There are adequate contingency plans to ensure an effective group programme during periods of planned staff leave.	97%
5.7.3	2	The ward timetable is scheduled to ensure that there is time for doctors to see patients without undue disruption to group attendance/the group programme.	100%
5.7.4	2	Patients have access to interventions that promote self-management, social inclusion and staying well plans, either on an individual or group basis.	100%
5.7.5	3	Family/Carers are able to access regular group meetings that have a psychoeducational and support focus.	77%
5.7.6	2	Patients are encouraged to provide mutual support by recruiting ex- patients as volunteers, and by current or former patients facilitating recovery and other groups.	74%
5.7.7	3	Carers are encouraged to provide mutual support by meeting with other carers at the ward/unit for patient recovery discussions and other groups.	74%
5.8		External Activities And Therapies	
5.8.1	2	Patients are able to leave the ward/unit to attend activities elsewhere in the building and, with appropriate supports and escorts, to access usable outdoor space every day.	100%
5.8.2	2	Staff support patients to self-manage therapeutic leave, with an understanding of therapeutic risk taking.	100%
5.8.3	2	The team provides information, signposting and encouragement to patients to access local organisations such as: - Voluntary organisations - Community centres - Local religious/cultural groups - Peer support networks - Recovery colleges	97%
5.9		Outcome Measures	
5.9.1	2	The service routinely evaluates outcomes using validated measures, including eating disorder-specific measures, generic measures and patient and family/carer perspective measures.	100%
5.9.2	2	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	100%
5.9.3	2	Clinical outcome monitoring includes reviewing patient progress against patient-defined goals in collaboration with the patient.	100%
5.1		Miscellaneous	
5.10.1	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency.	97%

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