QED
QUALITY NETWORK FOR EATING DISORDERS

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Quality Network for Eating Disorders: Standards for Adult Inpatient Services

Third Edition

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Date of publication: February 2021
Publication number: CCQI357

Contents

SECTION ONE: ACCESS AND ADMISSION			
Number	**Type**	**Standard**	**CCQI Core**
1.1	**Access and referral**		
1.1.1	1	The service provides information about how to make a referral.	1.1
1.1.2	1	Where part of a provider collaborative, the ward follows an agreed standard operating procedure around managing standards for referral. *Guidance: If not part of a collaborative, the ward has a protocol for managing referrals outside standard provider collaborative pathways which includes reviewing referrals, assigning priority and responding to the provider within two days of receipt.*	
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.	
1.1.4	1	The unit admits both male and female patients.	
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: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development.	2.4
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.	2.5
1.2.3	1	Patients are informed of the outcome of their physical health assessment and this is recorded in their notes. *Guidance: With patient consent, this can be shared with their carer.*	
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.	
1.2.5	1	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (e.g. children, people they are caring for); • Arrangements for pets; • Essential maintenance of home and garden.	2.7
1.2.6	2	A formal written report follows within 14 days of assessment with the service.	
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.	

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.	4.2
1.2.9	2	A representative from the community eating disorder team is invited to attend the first review.	
1.2.10	2	The ward/unit provides written feedback to referrers a minimum of once every six weeks.	
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. *Guidance: This may be achieved virtually, e.g. through a video tour.*	
1.3.2	1	On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital. *Guidance: Staff members show patients around and introduce themselves and other patients, offer patients refreshments and address patients using the name and title they prefer.*	2.1
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.	2.2
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.	13.3
1.3.5	3	The ward/unit can signpost to nearby facilities for family/carers to stay overnight when appropriate, and can advise on available funding.	
1.3.6	1	When a young person under the age of 18 is admitted: • There is a named CAMHS clinician who is available for consultation and advice; • The local authority or local equivalent is informed of the admission; • The CQC or local equivalent is informed if the patient is detained; • A single room is used.	1.2
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.	2.8

SECTION TWO: ENVIRONMENT AND FACILITIES			
Number	**Type**	**Standard**	**CCQI Core**
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.	
2.1.2	1	The unit is clean, comfortable and well-maintained.	
2.1.3	2	Staff members and patients can control heating, ventilation and light. *Guidance: For example, patients are able ventilate their rooms through the use of windows, they have access to light switches and they can request adjustments to control heating.*	17.15
2.1.4	2	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	17.19
2.1.5	1	The ward/unit has a designated dining area, which is reserved for dining only during allocated mealtimes.	
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.	
2.1.7	2	The ward/unit has a designated room for physical examination and minor medical procedures.	17.17
2.1.8	1	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	
2.1.9	2	Laundry facilities are available to all patients.	
2.1.10	2	All patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population. *Guidance: This may include recent magazines, daily newspapers, board games, a TV and DVD player with DVDs.*	17.7
2.1.11	1	Patients have access to safe outdoor space every day.	6.1.11
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.	
2.1.13	3	All patients can access a charge point for electronic devices such as mobile phones.	17.8
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.	
2.1.15	2	There is a designated space for patients to receive visits from children, with appropriate facilities such as toys and books. *Guidance: Children should only visit if they are the offspring of or have a close relationship with the patient and it is in the child's best interest to visit.*	
2.1.16	2	Ward/unit-based staff members have access to a dedicated staff room.	17.23

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. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	17.9
2.2.2	1	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	16.3
2.2.3	1	Male and female patients have separate bedrooms, toilets and washing facilities.	17.1
2.2.4	2	All patients have single bedrooms.	17.2
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.	17.1
2.2.6	2	There is secure, lockable access to a patient's room, with external staff override.	
2.2.7	2	The ward/unit has at least one bathroom/shower room for every three patients.	17.4
2.2.8	3	Every patient has an en-suite bathroom.	17.5
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.	17.6
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.	
2.2.11	2	Consideration is given to reduce the impact of a noisy environment on patients.	
2.2.12	1	There is a separable gender-specific space which can be used as required.	17.20
2.2.13	1	Patients can make and receive telephone calls in private.	
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. *Guidance: Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.*	17.11
2.2.15	2	Patients are able to personalise their bedroom spaces. *Guidance: For example, patients are able to put up their own photos and pictures.*	17.3
2.2.16	2	Patients are consulted about changes to the ward/unit environment.	17.24

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. *Guidance: This includes avoiding the use of blanket rules and any restrictions should be assessed based on individual risk.*	17.13
2.3.2	1	The ward/unit is a safe environment with no ligature points, clear sightlines (e.g. with use of mirrors) and safe external spaces.	17.12
2.3.3	2	Doors have viewing panels or observation windows and their use is managed to balance privacy and safety.	
2.3.4	1	Patients and staff members feel safe on the ward/unit.	21.2
2.4	**Equipment and procedures for dealing with emergencies on the ward/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.	7.3
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.	17.14
2.4.3	1	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	17.16
2.4.4	1	Hypostop or equivalent is available on the ward/unit, with guidance on its safe use.	

SECTION THREE: STAFFING AND TRAINING			
Number	**Type**	**Standard**	**CCQI Core**
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. *Guidance: This must be a specialist in eating disorders and not a general adult psychiatrist.*	
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.	19.3
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.	
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.	6.1.2
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.	6.1.3
3.1.6	3	There is dedicated sessional input from creative therapists.	6.1.4
3.1.7	2	A specialist pharmacist is a member of the MDT.	6.2.5
3.1.8	1	There are written documents that specify professional, organisational and line management responsibilities.	
3.1.9	1	Full MDT clinical review meetings occur at least once a week.	
3.2	**Staff working on the ward/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. *Guidance: This should include:* *• The physical care of patients with eating disorders;* *• Mealtime protocols;* *• The highly structured nature of eating disorder treatment;* *• The ward/unit programme;* *• Access to food, drink and exercise;* *• Suitable topics of conversation, with particular reference to discussions about weight, shape and eating;* *• Holding and managing boundaries with patients;* *• Developing therapeutic alliance.*	

3.2.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes: • Arrangements for shadowing colleagues on the team; • Jointly working with a more experienced colleague; • Being observed and receiving enhanced supervision until core competencies have been assessed as met.	20.2
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). *Guidance: This contains clear objectives and identifies development needs.*	
3.3.2	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	20.3
3.3.3	2	All staff members receive line management supervision at least monthly.	20.4
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.	18.1
3.3.5	2	Staff members in training and newly qualified staff members are offered weekly supervision and supported to attend.	
3.3.6	1	The ward/unit actively supports staff health and well-being. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	21.1
3.3.7	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	21.3
3.3.8	2	The team has protected time for team-building and discussing service development at least once a year.	
3.4	**Staff are provided with a thorough programme of training, relevant to an eating disorder setting**		
3.4.1		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:	22.1
3.4.1a	1	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance, basic life support.*	22.1e
3.4.1b	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a

3.4.1c	1	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	[unnumbered]
3.4.1d	1	Prevention and management of violence and aggression, including the use of restraint for nasogastric feeding.	
3.4.1e	1	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm, and the prevention and management of aggression and violence.*	22.1c
3.4.1f	1	Physical health assessment. *Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input.*	22.1b
3.4.1g	1	Recognising and communicating with patients with autistic spectrum disorders.	22.1d
3.4.1h	1	Managing distorted perceptions of food and body image.	
3.4.1i	1	Managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	
3.4.1j	2	Care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning.	
3.4.1k	2	Carer support and awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	22.1f
3.4.1l	2	Clinical outcome measures.	
3.4.2	2	Staff members are supported to access leadership and management training appropriate to their role and specialty.	
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.	6.2.4
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.	
3.4.5	2	Staff who are involved in supporting patients' mealtimes have been trained in meal and post-meal support.	
3.4.6	1	Staff implementing enteral feeding are trained using a competency-based framework and assessed a minimum of annually.	
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.	22.1g
3.4.8	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	6.1.13
3.4.9	2	Patients and/or carers are involved in delivering and developing staff training face-to-face.	22.2

3.5	**The levels of staff on the ward/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: • 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.	19.1
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.	19.2
3.5.3	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting potential staff members.	20.1
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.	18.2
3.5.5	1	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	18.3

SECTION FOUR: CARE AND TREATMENT			
Number	**Type**	**Standard**	**CCQI Core**
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. *Guidance: The care plan clearly outlines:* *• Agreed intervention strategies for physical and mental health;* *• Measurable goals and outcomes;* *• Strategies for self-management;* *• Any advance directives or statements that the patient has made;* *• Crisis and contingency plans;* *• Review dates and discharge framework.*	4.3
4.1.2	1	All patients have a documented diagnosis and a clinical formulation. *Guidance: The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*	
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.	2.6
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.	7.2
4.1.5	1	Patients with poor personal hygiene have a care plan that reflects their personal care needs. *Guidance: This could include encouragement to have regular showers and to shave, referral to a dentist for oral dentition, referral to a podiatrist for foot care.*	
4.1.6	3	The team supports patients to attend other health and social care-related appointments as an inpatient, when necessary. *Guidance: This includes supporting patients to register with a GP if in a new area.*	10.1
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.	
4.1.8	1	The ward/unit has a care pathway for women who are pregnant or in the postpartum period. *Guidance: Women who are over 32 weeks pregnant or up to 12 months postpartum period should not be admitted to a general psychiatric ward unless there are exceptional*	10.3

		circumstances.	
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.	6.1.1
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. *Guidance: This includes activities such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants.*	6.1.6
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. *Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who understands group dynamics.*	6.1.9
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.	6.1.5
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: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	6.1.12
4.2.6	1	The team supports patients to access support with finances, benefits, debt management and housing.	10.2
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. *Guidance: This is undertaken promptly and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.*	7.1
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.	
4.3.3	1	Patients in the early stages of refeeding are monitored closely for signs of biochemical, cardiovascular and fluid balance disturbance.	

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).	
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.	
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.	6.1.7
4.4.4	1	Patients know who the key people are in their team and how to contact them if they have any questions.	4.1
4.4.5	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	13.1
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. *Guidance: This could include paid peer support workers.*	
4.4.7	2	Carers are encouraged to meet with other carers from the ward/unit as part of a carers support group.	
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.	6.2.1
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. *Guidance: Side effect monitoring tools can be used to support reviews.*	6.2.2
4.5.3	1	Every patient's PRN medication is reviewed weekly, with consideration of the frequency, dose and reasons.	6.2.3
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.	7.4
4.6	**Food**		
4.6.1	1	Staff members ask patients for feedback about the food and this is acted upon.	
4.6.2	3	The food is freshly cooked on the hospital premises, rather than being reheated.	
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.	17.22

4.6.4	1	Ward/unit staff provide post-meal/snack support to patients, appropriate to the individual's care plan.	
4.7	**Leave**		
4.7.1	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.	5.1
4.7.2	1	Staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare.	5.2
4.7.3	2	Patients have supported periods of home leave to develop independent eating and self-management well in advance of discharge.	
4.7.4	1	When patients are absent without leave, the team (in accordance with local policy): • Activate a risk management plan; • Make efforts to locate the patient; • Alert carers, people at risk and the relevant authorities; • Complete an incident form.	5.3
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.	23.1
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.	23.2

SECTION FIVE: INFORMATION, CONSENT AND CONFIDENTIALITY			
Number	**Type**	**Standard**	**CCQI Core**
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. *Guidance: Information can be provided in languages other than English and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.*	
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.	
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.	15.1
5.1.4	1	All patients have access to an advocacy service including IMHAs (Independent Mental Health Advocates).	10.4
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: • A description of the service; • The therapeutic programme; • Information about the staff team; • The unit code of conduct; • Key service policies (e.g. permitted items, smoking policy); • Resources to meet spiritual, cultural or gender needs.	3.1
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: • Their rights regarding admission and consent to treatment; • Rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	2.3
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.	16.1

5.2.4	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member, a ward round or in a psycho-education group. This should include information on both the short- and long-term risks of eating disorders.*	6.1.8
5.2.5	2	The team provides each carer with carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes 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.*	13.4
5.2.6	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.	13.2
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.	11.1
5.3.2	1	When patients lack capacity to consent to interventions, decisions are made in their best interests.	
5.3.3	1	The team knows how to respond to carers when the patient does not consent to their involvement.	16.2

SECTION SIX: RIGHTS AND SAFEGUARDING			
Number	**Type**	**Standard**	**CCQI Core**
6.1	**Compassion, dignity and respect**		
6.1.1	1	Staff members treat all patients and carers with compassion, dignity and respect.	14.1
6.1.2	1	Patients feel listened to and understood by staff members.	14.2
6.1.3	2	Carers feel supported by the ward staff members.	13.5
6.1.4	2	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	6.1.10
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.	
6.2.2	1	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse.	8.1
6.2.3	1	Patients are involved in decisions about their level of observation by staff.	8.2
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.	8.4
6.3	**Restrictive practice**		
6.3.1	1	The team uses seclusion or segregation only as a last resort and for brief periods only.	8.6
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.	
6.3.3	1	Staff members do not restrain patients in a way that affects their airway, breathing or circulation.	8.3
6.3.4	1	Repeated restraint of a patient is reviewed and a second opinion is sought and recorded.	
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. *Guidance: Audit data are used to compare the service to national benchmarks where possible.*	8.8
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.	8.5

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. *Guidance: This also includes the use of restraint to support NG feeding.*	8.7
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.	
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.	21.4

SECTION SEVEN: DISCHARGE			
Number	**Type**	**Standard**	**CCQI Core**
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.	
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.	9.1
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. *Guidance: The plan includes details of:* *• Care in the community/aftercare arrangements;* *• Crisis and contingency arrangements including details of who to contact;* *• Medication including monitoring arrangements;* *• Details of when, where and who will follow up with the patient.*	9.2
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.	9.3
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.	9.4
7.1.6	3	The team provides 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. *Guidance: The team provides transition mentors, transition support packs or training for patients on how to manage transitions.*	9.5
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.	9.6
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.	

SECTION EIGHT: CLINICAL GOVERNANCE			
Number	**Type**	**Standard**	**CCQI Core**
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.	
8.1.2	1	Staff members follow a lone working policy and feel safe when escorting patients on leave.	
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).	
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.	
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.	
8.1.6	1	There is a policy on the assessment and management of pressure sores.	
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.	24.1
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.	24.2
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.	24.3
8.2.4	1	The ward/unit asks patients and carers for feedback about their experiences of using the service and this is used to improve the service.	12.1
8.2.5	2	Services are developed in partnership with appropriately experienced patient and carers who have an active role in decision making.	12.2
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. *Guidance: This meeting should also be used as a mechanism to feed in and out of the patient community meeting.*	
8.2.7	2	The ward/unit team uses quality improvement methods to implement service improvements.	24.4

8.2.8	2	The team actively encourages patients and carers to be involved in QI initiatives.	24.5

ACKNOWLEDGEMENTS

The Quality Network for Eating Disorders is extremely grateful to the following people for their time and expert advice in the development and revision of these standards:

- Members of the Quality Network for Eating Disorders' Advisory Group;
- The patients and carers that contributed their views and opinions;
- Individuals who attended the standards consultation workshop;
- Individuals who contributed feedback via the e-consultation process.

Glossary of terms

Term	Definition
Advance directive	A set of written instructions that a person gives that specify what actions should be taken for their health if they are no longer able to make decisions due to illness or incapacity.
Advocacy services	A service which seeks to ensure that patients are able to speak out, to express their views and defend their rights.
Care plan	A systematic way of looking at the potential risks that may be associated with a particular activity or situation.
CPA	A Care Programme Approach is a package of care that is used by secondary mental health service. A CPA includes a care plan and someone to coordinate your care. A CPA aims to support a patient's mental health recovery by helping them to understand their strengths, goals, support needs and difficulties.
Clinical outcome measurement data	Clinical outcomes are measurable changes in health, function or quality of life that result from our care. Clinical outcomes can be measured by activity data such as re-admissions, or by agreed scales and others forms of measurement.
Clinical supervision	A regular meeting between a staff member and their clinical supervisor. A clinical supervisor's key duties are to monitor employees' work with patients and to maintain ethical and professional standards in clinical practice.
Co-produced	Refers to engaging and communicating with the service user and their family members (where appropriate) in the development of their care plan to ensure that support is person-centred.
Crisis plan	A crisis plan outlines key information to be considered during a mental health crisis, such as contact details, history of mental and physical illnesses, previous anti-depressants and psychotherapies, signs predicting relapse, and instructions for care if a future relapse

	occurs.
European Working Time Directive	Initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety.
Line management supervision	Supervision involving issues relating to the job description or the workplace. A managerial supervisor's key duties are prioritising workloads, monitoring work and work performance, sharing information relevant to work, clarifying task boundaries and identifying training and development needs.
Mental Capacity Act	A law which is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interests or for the safety of themselves or others.
Personal development plan	An action plan that helps to identify learning and development needs to help an individual in their job role or progress in their career.
Reflective practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Risk assessment	An action plan that helps to identify learning and development needs to help an individual in their job role or progress in their career.
Safeguarding	Protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect.
Statutory carers' assessment	An assessment that looks at how caring affects a carer's life, including for example physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring.