QED
QUALITY NETWORK FOR EATING DISORDERS

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Quality Network for Eating Disorders: Standards for Adult Inpatient Services

Fourth Edition

Editor: Ruby Lucas

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Contents

Quality Network for Eating Disorders (QED)

Royal College of Psychiatrists' Centre for Quality Improvement

21 Prescot Street

London

E1 8BB

www.rcsych.ac.uk/QED

QED@rcpsych.ac.uk

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Chair's Foreword

The Quality Network for Eating Disorders (QED) was established in 2012 to provide eating disorder services across the UK with a framework to guide the delivery of safe, effective and evidence-based care for people with eating disorders and their carers. Through the accreditation process facilitated by QED, services are provided with guidance and support to reach the highest quality of care. Alongside this, the peer review process provides opportunities for clinicians to meet and share areas of good practice and innovative developments in healthcare.

Reviewing the standards on a regular basis is a necessary cycle that ensures they remain realistic and relevant to the ever-changing needs of healthcare provision for this population whilst taking into account new evidence and changes in international guidelines. Additionally, since the last review, we have survived a global pandemic which resulted in substantial learnings and adaptations to service provision, with subsequent transformations in service delivery that have become the 'new normal'. Many of these changes have opened our minds to new ways of working, facilitating engagement with patients and carers who previously may have struggled to gain access to services.

Service users, carers and eating disorder clinicians from across the UK were invited to participate in the review consultation and we value the time and feedback from all those involved. In this review of the standards we have endeavoured to streamline the core standards and have changed the level of some standards to ensure they are consistent with current evidence and best practice. Throughout the review process, there was an emphasis on ensuring the standards were promoting dynamic risk assessment, using the least restrictive practice and a focus on inclusivity.

Over the years of accreditation review visits, we have had the opportunity to celebrate areas of good practice and this is something we would like to share with our QED members. The QED team have compiled a library of resources, with permission from the authors, which can be utilised to assist teams with standards they find challenging.

It is hoped this 4th edition of the standards will provide direction for service development and improvement which will positively impact on the patient journey and provide enhanced opportunities for recovery.

Hazel Elliot,

Advanced Dietetic Practitioner & QED Accreditation Committee Chair

Introduction

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes patients & carers, and email forums with professional groups involved in the provision of specialist eating disorder services. They incorporate the College Centre for Quality Improvement (CCQI) Core Inpatient Standards, as well as specialist standards relating specifically to inpatient eating disorder services.

Please contact the team at the College Centre for Quality Improvement (CCQI) for further information about the process of review and accreditation.

Who are these standards for?

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

CCQI core standards

The core standards are used by the quality networks and accreditation programmes within the College Centre for Quality Improvement (CCQI). Each project adopts the relevant core standards which will be used alongside the specialist standards that relate to the service type being reviewed. The core standard reference number can be viewed on the right-hand column throughout the document. Those that are not marked with a core number are specialist standards relating to inpatient mental health services that are not included in the core set.

Criteria

All criteria are rated as Type 1, 2 or 3.

Type 1: Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: Expected standards that most services should meet.

Type 3: Desirable standards that high performing services should meet.

Sustainability Principles

The fourth edition of the QED quality standards for inpatient eating disorder services has been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee.

(www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx)

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' [20].

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and

environmental determinants alongside the biological determinants of health).

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamworking facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Sustainability standards are marked throughout the document with the leaf icon.

SECTION ONE: ACCESS AND ADMISSION			
Number	**Type**	**Standard**	**CCQI Core Standard**
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 referrals. *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.	
1.1.5	1	The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. *Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.*	1.3
1.2	**Initial assessment**		
1.2.1	1	Patients have a comprehensive mental health assessment which is started within four hours of admission. 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 Sustainability Principle
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.	2.5 Sustainability Principle

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 (including children, people they are caring for); - Arrangements for pets. *Guidance: This could be identified by the patient's community team, or external services, pre-admission.*	2.7
1.2.6	1	In the case of non-attendance, contact is made between the ward/unit and the referrer immediately to inform, ascertain the patient's level of risk, and agree a plan.	
1.2.7	1	There is a documented formalised review of care 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
1.2.8	2	A representative from the community eating disorder team is invited to attend the patient's first review. The outcome of the review is shared with the referrer.	
1.2.9	3	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 them refreshments and address them using their preferred name and correct pronouns. Staff should enquire as relevant how they would like to be supported in regard to their gender.*	2.1

1.3.3	1	The patient's carer is contacted as soon as possible 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 Sustainability Principle
1.3.5	3	The service provides carers with information on admission, with patient's consent, about nearby facilities for overnight stays, where appropriate.	
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	Patients 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 Standard**
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 on the ward/unit. *Guidance: For example, patients are able to ventilate their rooms through the use of windows, they have access to light switches, and they can request adjustments to control heating.*	17.17

2.1.4	2	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	17.21
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.	17.19
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.*	17.8
2.1.11	1	Patients have access to safe outdoor space every day.	6.1.11 Sustainability Principle
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.	17.9
2.1.14	2	There is at least one room for interviewing and meeting with individual patients and carers/relatives, which is furnished with comfortable seating.	
2.1.15	1	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	17.12
2.1.16	3	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.*	

2.1.17	2	Ward/unit-based staff members have access to a dedicated staff room.	17.25 Sustainability Principle 
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.*	17.10
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. Room allocation should accommodate a spectrum of gender and patient gender self-identification should be supported wherever possible. *Guidance: Self-identification as male or female should be accepted, and allocation to a gendered room done with patients' agreement. Where this allocation could present risks to the patient or to vulnerable others, this is risk assessed and all practical steps taken to accommodate patient preference. If patient preference cannot be safely accommodated, this is discussed between the patient and clinical team and agreement made on the most appropriate environment for care.*	17.1
2.2.4	3	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.	17.3
2.2.5	2	All patients have single bedrooms.	17.2

2.2.6	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. *Guidance: There may be exceptions where indicated by the patient's risk. This should be documented in the patient's records.*	17.11
2.2.7	2	The ward/unit has at least one bathroom/shower room for every three patients.	17.5
2.2.8	3	Every patient has an en-suite bathroom.	17.6
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.	17.7
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.	17.22
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.*	17.13
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.*	17.4
2.2.16	2	Patients are consulted about changes to the ward/unit environment.	17.26
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 assessing risk on an individual basis.*	17.15
2.3.2	1	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.	17.14
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
2.3.5	1	In wards/units where seclusion is used, there is a designated room that meets the following requirements: - It allows clear observation; - It is well insulated and ventilated; - It has adequate lighting, including a window(s) that provides natural light; - It has direct access to toilet/washing facilities; - It has limited furnishings (which include a bed, pillow, mattress and blanket or covering); - It is safe and secure, and does not contain anything that could be potentially harmful; - It includes a means of two-way communication with the team; - It has a clock that patients can see.	17.20
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 Sustainability Principle
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.	17.18
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 Standard**
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 arts or creative therapists. *Guidance: This can be externally provided, although input should be regular and formalised.*	6.1.4
3.1.7	2	Patients and carers and prescribers are able to meet with a pharmacist to discuss medications.	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;* *• Carer involvement;* *• MEED guidance;* *• Using restraint appropriately.*	
3.2.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met.*	20.2
3.2.3	2	For non-regular agency staff, there is a brief induction to the ward which includes: • Tour of the unit (including locked doors and alarm systems); • Brief overview of current patients (including their observation levels, risks and triggers); • Roles and responsibilities; • Meal times and suitable topics of conversation; • Information specific to eating disorders. *Guidance: The service may use a summary document or folder that contains key information. Information should be appropriate to the staff member's role, skills, and knowledge and experience of eating disorders.*	
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 Sustainability principle 
3.3.5	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
3.3.6	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
3.3.7	2	The team has protected time for team-building and discussing service development at least once a year. *Guidance: This could be held virtually.*	
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	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a
3.4.1b	1	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	22.1c Sustainability principle 

3.4.1c	1	Prevention and management of violence and aggression, including the use of restraint for nasogastric feeding.	
3.4.1d	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*.	22.1d
3.4.1e	1	Physical health assessment and MEED guidance. *Guidance: This could include training in understanding physical health problems, physical observations and when to refer the patient for specialist input*.	22.1b
3.4.1f	1	Recognising and communicating with autistic people.	22.1e
3.4.1g	1	Managing distorted perceptions of food and body image.	
3.4.1h	1	Working with patients with co-morbidities and understanding the impact of trauma within eating disorders.	
3.4.1i	2	Care planning as part of the care management programme, including CPA (or local equivalent) and discharge planning.	
3.4.1j	2	Carer support and awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	22.1g
3.4.1k	2	Clinical outcome measures.	
3.4.1l	1	Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	22.1f
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. The assessment is completed at least once every three years using a competency-based tool.	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 when they are inducted into a Trust or changing wards. This includes: - 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; - Actions to take if the patent absconds.	22.1h
3.4.8	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	6.1.14
3.4.9	2	Patient and carer representatives are involved in delivering and developing staff training.	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 Sustainability principle
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 Sustainability principle
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 Sustainability principle
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 Standard**
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: Where possible, the patient writes the care plan themselves or with the support of staff.*	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 safety plan which is co-produced (where the patient is able to participate), updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). *Guidance: This assessment considers risk to self, risk to others and risk from others.*	2.6 Sustainability principle
4.1.4	1	Patients are offered personalised healthy lifestyle interventions appropriate to an eating disorder setting, such as advice on appropriate and risk assessed physical activity and access to smoking cessation services. This is documented in the patient's care plan.	7.2 Sustainability principle
4.1.5	3	The team supports patients to attend an appointment with their community GP if they need to whilst an inpatient, if they are admitted in the local area.	10.1
4.1.6	2	The ward/unit has a process for how to access specialist services to treat co-morbid conditions (including substance misuse), and staff are aware of how to access these services.	
4.1.7	1	The ward/ unit has a care pathway for patients who are pregnant or in the postpartum period. *Guidance: Patients who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.*	10.3

4.2	Programme of care and treatment		
4.2.1	1	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.	6.1.1
4.2.2	2	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. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.*	6.1.9
4.2.4	2	Patients receive psychoeducation on topics about activities of daily living, 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.	6.1.13
4.2.6	1	The team supports patients to access support with finances, benefits, debt management and housing needs.	10.2
4.2.7	2	Patients, according to risk assessment, have access to regular 'green' walking sessions. *Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rain wear.*	6.1.12 Sustainability Principle

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 is offered a one-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 are supported to participate actively in decision making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents.	13.1 Sustainability principle 
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	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, 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 and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	6.2.2 Sustainability principle 
4.5.3	1	Every patient's PRN medication is reviewed weekly: frequency, dose and indication.	6.2.3
4.5.4	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon.	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 are suitable for the patient's need and are in line with the dietetic plan. Meals are varied and reflect the individual's cultural and religious needs.	17.24
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 and ability to access bed on return.	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): - Activates a risk management plan; - Makes efforts to locate the patient; - Alerts carers, people at risk and the relevant authorities; - Escalates as appropriate.	5.3
4.8	**Clinical outcome measurement**		
4.8.1	1	Clinical outcome measurement is collected at two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements 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 Standard
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 practically possible. The information includes: - Their rights regarding admission and consent to treatment; - Their rights under the Mental Health Act; - How to access advocacy services; - How to access a second opinion; - How to access interpreting services; - How to view their health 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.	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 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. *Guidance: The team may receive information from the carer in confidence*.	16.2

SECTION SIX: RIGHTS AND SAFEGUARDING			
Number	**Type**	**Standard**	**CCQI Core Standard**
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 (wherever possible) in decisions about their level of therapeutic observation by staff. *Guidance: Patients are also supported to understand how the level can be reduced*.	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 only as a last resort and for brief periods only.	8.7
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	When restraint is used staff members restrain in adherence with accredited restraint techniques.	8.3
6.3.4	1	Repeated restraint including prolonged nasogastric feeding of a patient is reviewed at a minimum of every 6 weeks 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, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. *Guidance: Audit data are used to compare the service to national benchmarks where possible*.	8.10
6.3.6	1	Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018.	8.5
6.3.7	1	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs and make advance statements about the use of restrictive interventions.	8.6

6.3.8	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.*	8.9
6.3.9	1	Restrictive interventions with regards to feeding are used in line with MEED guidelines. They are only used in life-threatening situations or as part of a carefully considered multi-disciplinary care plan. If used, they are reviewed at every ward round/review.	
6.3.10	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. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection.*	21.4 Sustainability principle 

SECTION SEVEN: DISCHARGE			
Number	**Type**	**Standard**	**CCQI Core Standard**
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 person's personal, social, safety and practical needs to reduce the risk of suicide on discharge. *Guidance: Where possible, this should be completed in partnership with carers.*	9.1
7.1.3	1	The team sends a copy of the patient's care plan or interim discharge summary 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 Sustainability principle
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 team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 72 hours 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 MEED-compliant.	

SECTION EIGHT: CLINICAL GOVERNANCE			
Number	**Type**	**Standard**	**CCQI Core Standard**
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 report incidents quickly and effectively, and managers encourage staff members to do this.	24.1
8.2.2	1	When serious mistakes are made in care, this is discussed with the patient themself and their carer, in line with the Duty of Candour agreement.	24.2

8.2.3	1	Lessons learned from untoward incidents and complaints are shared with the team and 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 Sustainability Principle 
8.2.5	2	Feedback received from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics.	12.2
8.2.6	2	Services are developed in partnership with appropriately experienced patient and carers who have an active role in decision making.	12.3
8.2.7	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.*	
8.2.8	3	The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team.	
8.2.9	2	The team is actively involved in QI activity.	24.4
8.2.10	2	The team actively encourages patients and carers to be involved in QI initiatives.	24.5

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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.