Thors Park

Quality Report

Thors Farm Road
Brightlingsea Road
Thorrington
Colchester
Essex
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Thors Park as **requires improvement** because:

- There was little evidence seen in regional meeting minutes regarding lessons learned from incidents or complaints.
- The window handles in the conservatories were not anti-ligature and there were some exposed wires by the fascias in the garden on Thorrington ward.
- The provider used a large number of agency staff and from 01 June 2016 to 31 August 2016; 29 shifts had not been covered. This meant that the wards did not have safe staffing levels on these days.
- Patients had not signed their care plans. Staff and not recorded whether a copy had been given to the patient.
- Staff had not recognised or recorded two episodes of seclusion in accordance with the Mental Health Act Code of Practice.
- The provider had not ensured that when a patient lacked capacity to make decisions, decisions made on their behalf were not documented appropriately.
- Staff compliance with mandatory training was low at 64% of staff up to date with mandatory training. The providers target was 80%.

However:

- Since the last inspection Thorrington ward had been renovated; the bedrooms, lounge, dining area and corridors had been decorated and there was new furniture and sanitary ware. The provider was due to bring Brightlingsea ward up to a similar standard, although no date was given when the works would be completed.
- The provider held staff profiles on agency staff members that worked on the wards. These contained qualifications, disclosure and barring service (DBS) records, references and training records.
- The provider used an electronic recording system to update patient records in the weekly multi-disciplinary team meeting.
- Staff showed a good understanding of the individual needs of the patients, and we observed good interactions between staff and patients.
- The provider provided easy read multi-disciplinary meeting forms for patients to complete prior to them attending the meeting to give feedback to the team.
- We saw good evidence of patient involvement in the recruitment of staff, for example being a part of the interview panel.
- We observed proactive discharge planning in the multi-disciplinary meeting. The provider ensured patients' beds remained available following return from periods of leave.
- The provider was a member of the Award Scheme Development and Accreditation Network, which was designed to develop alternative education provision.
- Notes were observed to be patient centred and holistic.
- We saw six medication charts which all had consent to treatment forms attached.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Requires improvement 	• Thorrington ward is an eight-bed unit for men with learning disabilities, complex needs and/or challenging behaviours. • Brightlingsea ward is a four-bed unit for men needing more intensive support than is provided in Thorrington ward. • There are two bespoke units for men who are unable to tolerate living in shared accommodation

Summary of findings

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Requires improvement

Thors Park

Services we looked at

Wards for people with learning disabilities or autism;

Summary of this inspection

Background to Thors Park

Thors Park is an independent hospital that provides support for up to 14 men. There are three elements to the service:

- Thorrington ward is an eight-bed service that provides assessment and intervention for men living with learning disabilities, complex needs and/or behaviours that can be perceived as challenging.
- Brightlingsea ward is a four-bed service that provides 24-hour care and support. The service offers a structured and therapeutic environment for individuals who require more intensive support than is provided in Thorrington ward.
- There are two bespoke units for men who are unable to tolerate living in shared accommodation

Thors Park has been registered with the CQC since 28 November 2012.

Thors Park was last inspected in September 2015 where it was found:

- The provider did not ensure that all bathrooms were hygienic and free from stains and dirt. Cleaning records were not fully completed – This was a breach of regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had now dealt with this.
- Providers should use appropriate cleaning methods and agents, operate a cleaning schedule appropriate to the care and treatment being delivered. This was a breach of regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider had now dealt with this issue.
- The provider did not ensure that staff regularly monitored and reviewed long-term segregation– This was a breach of regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whist we found that improvements had been made the provider had not fully addressed this issue.

Our inspection team

Our inspection team was led by: Margaret Eaves-Fletton, inspector, MH hospitals

The team that inspected the service comprised three inspectors.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about the location, and asked stakeholders for information.

During the inspection visit, the inspection team:

- visited the two wards and one bespoke unit at the hospital.
- looked at the quality of the ward environment and observed how staff were caring for patients.

Summary of this inspection

- spoke with three patients who were using the service.
- spoke with the appointed manager who has applied to become registered manager, the director of operations and the two deputy managers for the service.
- spoke with nine other staff members; including a doctor, nurses, occupational therapist, speech and language therapist and psychologist.
- attended and observed a multi-disciplinary meeting.
- collected feedback from 14 comment cards.
- spoke with one carer.
- looked at eight care and treatment records of patients.
- looked at six medication charts.
- carried out a specific check of the medication management on two wards, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

completed a follow-up visit on 20 December 2016.

What people who use the service say

The complex nature of the hospital's patient group meant that it was difficult to engage with most patients as part of this inspection. When we observed direct patient care, patients appeared happy and sought support from staff when needed. However:

- Patients told us that the food is good.
- One patient said that there are enough activities, although one said there was not enough to do.
- Staff and patients told us that no leave had to be cancelled due to lack of staff.
- Patients told us that they felt safe.
- One patient said he felt able to talk to staff.
- Patients told us that the ward was comfortable.
- Patients told us that most staff are good.
- One patient told us he knew how to make a complaint.
- One carer we spoke with had some concerns that care of her son's clothes did not come up to her standard.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as **requires improvement** because:

- The window handles in the conservatories were not anti-ligature. Staff identified these within the ligature risk assessment.
- There were some exposed wires by the fascia's in the garden on Thorrington ward.
- The provider had been unable to cover 29 shifts in a three-month period.
- There had been 34 substantive staff leavers in the 12-month period to August 2016.
- Staff compliance with mandatory training was low. Nine of the 14 mandatory training courses were below the organisation target of 80%.
- We saw records of two episodes of seclusion that staff had not documented as an incident of seclusion.

However:

- The provider had updated the clinical environment on Brightlingsea Ward since the last inspection. The provider had decorated the bedrooms, lounge, dining area and corridors and there was new furniture and sanitary-ware. Thorrington ward was due to be brought up to a similar standard, although no date was given when the works were to be completed.
- The provider held staff profiles on agency staff members that worked on the wards. These contained qualifications, disclosure and barring service records, references and training records.
- The service manager was able to adjust staffing levels utilising the rolling rota, which enabled safe staffing.
- There was an active recruitment plan.
- Each ward had an accessible emergency bag which included a ligature cutter.
- Medicines were stored securely and in accordance with the provider policy and manufacturers' guidelines.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

Summary of this inspection

- The provider was not completing annual appraisals with staff. Only 14% of staff had received an annual appraisal. This meant the provider was not monitoring staff performance on a regular basis.
- Staff did not receive regular managerial supervision. One staff record showed they had not received supervision between September 2014 and August 2015.
- Data provided showed that 43% of staff had completed the Mental Health Act training.
- Data provided showed that 46% of staff had completed the Mental Capacity Act and Deprivation of Liberty Safeguards training.
- Staff did not fully complete mental capacity documentation. Ten best interest forms for one patient concluded that the patient lacked capacity but did not give any details of decisions made in the patient's best interest.

However:

- The provider used an electronic recording system to update patient records in the weekly multi-disciplinary team meeting.
- We observed Notes to be patient centred and holistic.
- Staff attached consent to treatment forms to medication cards.
- Patients had access to one to one and group occupational therapy and psychology interventions.
- We saw evidence of physical health care routinely promoted in patient notes.
- Staff could access specialist training, for example in phlebotomy, positive behavioural support, and autism.
- Managers carried out investigations and put support plans in place to improve the practice of staff members.

Are services caring?

Good

We rated caring as **good** because:

- Staff showed a good understanding of the individual needs of the patients, and we observed good interactions between staff and patients.
- Staff treated patients with dignity and respect.
- There was evidence of patient involvement in their care.
- Staff supported patients to attend their daily activities and their planned therapeutic programme.
- The provider used easy read multi-disciplinary meeting forms for patients to complete, prior to them attending the meeting to give feedback to the team.

Summary of this inspection

- The multi-disciplinary team (MDT) told us that patients were always invited to the MDT meetings, but many were unable to tolerate this environment. Staff told us the advocacy service would support the patient to share their views.
- We saw good evidence of patient involvement in the recruitment of staff, for example being a part of the interview panel.
- Patients attended service user forum meetings supported by the occupational therapist.

However:

- Staff did not get patients to sign their care plan or record whether a copy had been given to the patient.

Are services responsive?

Good

We rated responsive as **good** because:

- The provider had a proactive approach to discharge planning; which we observed during a multi-disciplinary meeting. The provider ensured patients' beds remained available following return from periods of leave.
- The provider had a range of rooms for care and treatment for patients. For example, there was an occupational therapy suite, with a kitchen for assessments and interventions, a sensory room, and large craft/activity room.
- There were rooms available for patients to have visitors and privacy.
- The hospital was set in a 30-acre site, and there was access to secure outside space for both wards.
- The hospital had a dedicated chef who provided a wide choice of meals to cater for individual dietary needs.

However:

- The provider did not ensure that staff received feedback from the outcomes of complaints and incidents. Staff told us they felt there was poor feedback from incidents and complaints.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- We could not find evidence that senior managers discussed incidents or complaints during regional governance meeting minutes. There was no evidence that themes and trends were identified at a senior level.
- Managers had not ensured that all staff received regular supervision.

Summary of this inspection

- Managers had not ensured that all staff received a yearly appraisal.
- Managers had not ensured that compliance with mandatory training met the organisation's target of 80%. Managers told us they had put plans in place to address this.

However:

- The hospital published monthly newsletters to update staff on changes in the organisation.
- Staff knew who the senior managers were and reported that they were approachable and supportive.
- The area director was based at Thors Park and this provided increased visibility to staff.
- Staff told us morale was good and an active recruitment plan is in place with regular interviews taking place.
- Staff we spoke with told us that they are aware of their responsibilities concerning being open and honest when things had gone wrong.
- The provider was accredited by the award scheme development and accreditation network, which was designed to develop alternative education provision.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The provider required staff to complete mandatory training in the Mental Health Act. However, only 43% of staff had received this training. Management were now allocating training in line with the new rolling rota. Staff completed the rota for the remainder of the year and was available to staff six weeks in advance. Staff demonstrated a good understanding of the MHA and Code of Practice.
- Patients could access the independent mental health advocate. An independent advocate is specially trained to support people to understand their rights under the Mental Health Act and participate in decisions about their care and treatment.
- The Mental Health Act administrator completed audits on the application of the Mental Health Act and Code of Practice.
- Doctors granted some patients section 17 leave. We saw that the forms included frequency and duration of the leave authorised for each individual patient.
- Staff completed records of patients' consent to treatment and recorded these in the patient records. Staff attached copies of consent to treatment forms to medication charts.
- We saw evidence that patients had their rights under the Mental Health Act explained to them on admission and routinely thereafter.
- Staff completed detention paperwork correctly and kept copies in the patient notes for staff reference.
- The provider had updated Mental Health Act policies in line with the new code of practice.
- Patients had access to independent mental health advocate services and staff were clear on how to access and support engagement with the service. We saw posters in the reception area and on wards advertising this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

Please provide information about the Provider's adherence to the Mental Capacity Act and Deprivation of liberty safeguards.

- The provider required staff to complete mandatory training in the Mental Capacity Act. However, only 43% of staff had received this training. The training was now being allocated in line with the new rolling rota. The rota was completed for the remainder of the year and was available to staff six weeks in advance. Staff Independent mental capacity advocates were available to support patients who lacked capacity.
- The provider had a policy on the Mental Capacity Act, which included Deprivation of Liberty Safeguards information for staff reference.
- The provider had a dedicated mental health administrator responsible for the monitoring of adherence to the Mental Capacity Act within the service.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- There were some blind spots on both wards in the bedroom corridors. There was CCTV in place which could be monitored in the staff office. However, Staff did not monitor this unless there was an incident.
- There were ligature points in the conservatories on the window handles and ceiling window mechanism. We reviewed the ligature risk assessment, which included all identified ligature points, and action plans to mitigate these. The provider has plans to renovate the conservatories in 2017 and fit anti-ligature handles.
- There were some exposed wires by the fascias in the garden on Thorrington ward. The provider had an action plan to rectify this.
- Both wards were male only wards and therefore complied with same sex accommodation guidance.
- The provider had a well-equipped clinic room and there was access to emergency resuscitation equipment. Staff checked equipment on a weekly basis. Staff monitored the fridge and room temperature on a daily basis.
- There was no seclusion room at the hospital.
- The wards were clean and tidy and the provider had recently renovated Thorrington ward. The provider had decorated the bedrooms, lounge, dining area and corridors and there was new furniture. The provider had plans to update the environment on Brightlingsea ward although no time line was given for this. Furnishings were well maintained, comfortable, and suitable for the environment. The conservatories on each ward were in need of repair as there was peeling paint and they looked dirty. The provider had an action plan to renovate these in 2017.
- We saw evidence that all staff adhered to infection control principles including handwashing.
- Staff regularly maintained and cleaned equipment. We reviewed the cleaning records, which was up to date with no gaps.
- Staff completed environmental audits, which highlighted areas of concern within the hospital. Maintenance staff would the make the necessary improvements.
- Staff had personal alarms across all wards. Reception staff issued personal alarms to visitors to ensure their safety.

Safe staffing

- The provider had estimated the number of substantive staff as 63. The provider had an establishment of five whole time equivalent registered nurses. The provider had two vacant posts. The provider had a whole time equivalent establishment of 52 support workers with 28 vacant posts. The provider had an active recruitment plan.
- The number of shifts covered by agency staff for the period from 01 June 2016 to 31 August 2016 was 672. In the same period the provider was unable to cover 29 shifts. In busy periods the activities co-ordinator, management team, and all qualified nurses on duty assisted to cover the ward.
- Staff sickness rate was 5% in the last 12 months.
- Data provided showed 34 substantive staff leavers in the 12 month period to August 2016. This equates to 54% of

staff. The managers explained that this was during a period of unsettled management as they had two managers leave within a short period. This had caused a period of low staff morale.

- The provider used regular agency staff. These were block booked to ensure continuity for patients. New agency staff would have to undergo the providers' induction prior to starting on the ward.
- Regular bank staff that knew the patients were booked through a recruitment agency to ensure continuity of care and were familiar with the wards. The provider block-booked named bank nurses in advance. The provider held staff profiles on agency staff members that worked on the wards. The profiles held up to date information about staff qualifications, disclosure and barring service (DBS) records, references and training records.
- The service manager was able to adjust staffing levels daily, taking account of patient mix. A rolling rota of two teams had been introduced which enabled safe staffing.
- A qualified nurse was present in communal areas of both wards at all times.
- Staff told us that there was enough staff so that patients could have one to one time with either their named nurse or another member of staff.
- Staff and patients told us they rarely cancelled leave due to staff shortages. Patients told us that staff would rearrange leave rather than cancel it. Staff would explain to patients the reasons why they had to rearrange the leave and plan another time.
- There was sufficient staff to carry out physical interventions when necessary.
- The consultant was available out of hours for advice and guidance with patients. However if there was a medical emergency staff would call an ambulance.
- The provider did not ensure all staff were up to date with mandatory training. Staffs compliance rate with mandatory training was 64%; fire safety training, safeguarding, medication management, data protection, positive behaviour support, food safety, health and safety, Mental Health Act, Mental Capacity Act/DoLS and moving and handling all fell below the providers 80% target. However, management implemented the new rolling rota had been completed for the rest of the year with training dates allocated to each staff member. They told us that new starters and the travel to mandatory training mitigated some of the low percentage. The process of moving training to a nearer location had started and attendance had begun to increase.

Assessing and managing risk to patients and staff

- Staff did not document episodes of seclusion in line with the Mental Health Act Code of Practice. Data supplied by the provider showed there were no instances of seclusion or segregation for the period 01 February 2016 to 31 August 2016. However, we saw documentation of two care interventions that met the Mental Health Act Code of Practice definition of seclusion. For one of the incidents staff had written a care plan for the intervention as a way of helping the patient calm down when agitated, however staff did not document these interventions as seclusion despite it meeting the criteria. We highlighted this to the manager during inspection.
- Staff had used restraint on 16 occasions between February and August 2016. This involved five different patients. Staff did not use prone (face down) restraint. Staff told us that they used physical restraint as a last resort if de-escalation was unsuccessful. Staff received mandatory training in physical intervention skills, which had been accredited by the British Institute of Learning Disabilities. Data showed that 92% of staff had completed this training.
- We reviewed eight care and treatment records. Staff had completed risk assessments on admission and they reviewed them regularly during care review meetings or as required following an incident or change in risk.
- We did not observe any blanket restrictions at the hospital.
- The provider had good observation protocols in place. Staff used different levels of observation dependent on the level of risk. There was a policy for searching patients. This would be done upon return from leave if a patient was at risk of bringing contraband into the hospital.
- Staff had not used rapid tranquilisation within the period between February and August 2016. Staff told us that when they used rapid tranquilisation they followed the National Institute for Health and Care Excellence (NICE) guidelines.

Requires improvement

Wards for people with learning disabilities or autism

- We reviewed the training log, which showed that 84% of staff were trained in safeguarding adults and children. Staff we spoke to knew how to make a safeguard alert and were able to describe what would constitute a safeguarding concern.
- There were good medicines management procedures in place. We reviewed six medication records, which showed that staff were recording the dispensing of medication appropriately. Medication was stored in a locked cupboard with a separate cupboard for controlled drugs. Staff did a quarterly check on the clinic room to make sure medication was stored and managed in line with Nursing and Midwifery Council (NMC) guidelines. The provider used a local pharmacy for medication reconciliation. They would attend the hospital every two weeks to check stock.
- The provider had arrangements for children to visit. Children were not allowed to visit on the main ward areas, however, alternative visiting arrangements were provided in the occupational therapy suite.

Track record on safety

- The provider reported nine serious incidents requiring investigation between 14 September 2015 and 04 July 2016. They related to patient abuse to staff and a member of the public away from the hospital premises; a patient physically assaulted another patient; four allegations of abuse to a patient from staff; patient demonstrating abusive sexual behaviour; and three allegations of patient abuse to another patient.
- The service manager attended monthly regional internal reviews they discussed serious incidents and adverse events. We reviewed the minutes of these meetings and saw that serious incidents were a regular agenda item.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents. Non-registered staff completed a paper report, which qualified staff uploaded onto the electronic incident recording system. Ward managers would then review and investigate them.
- Managers gave feedback from incidents at staff meetings. We reviewed team meeting minutes, which showed evidence of discussion concerning critical incidents, incident reporting, the need to include incident reporting as a rolling agenda item and health and safety.
- Staff were able to attend debrief sessions following incidents. This was facilitated by the psychologist

Duty of Candour

Staff we spoke with told us that they were aware of their responsibilities concerning being open and honest when things had gone wrong. Staff were aware of the providers complaint policy and their requirement to be open and honest.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff completed a thorough assessment of assessment of patients' needs after admission. Staff used information gathered during this assessment to formulate a care plan.
- Staff did not always record physical health checks on admission. We reviewed eight care records and three did not show physical health care checks on admission. However, there were ongoing physical health care checks recorded.
- Staff completed care plans that were holistic and recovery focussed. These covered a range of needs including personal care needs, diet and nutrition and activities. Staff reviewed these regularly during patients care review meetings. However, staff had not given patients a copy of their care plans or asked them to sign them to say they agreed with them.
- The provider used an electronic recording system to update patient records. Staff also kept paper records. We reviewed eight care records, which were patient centred and holistic. All staff had access to the electronic recording system including bank staff.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidelines for prescribing medication. Staff told us they followed National Institute for Health and Care Excellence guidance on the use of antipsychotic medication. We reviewed the medication card and saw that medical staff prescribed anti-psychotic medication in line with NICE guidance.
- Staff provided psychological interventions recommended by National Institute for Health and Care Excellence . These included Clinical Outcomes in Routine Evaluation, which is an outcome-rating tool, neuropsychological testing, and functional analysis.
- Patients had access to physical health care. The provider had access to a locum GP who attended the service. Staff completed regular physical health monitoring for patients and accessed specialists via referral from the GP.
- Staff used recognised rating scales such as Health of the Nation Outcome Scales and Clinical Outcomes in Routine Evaluation . We saw evidence that staff completed these within the care records.
- Staff were involved in clinical audits such as clinic room checks, care plan and risk assessment audits.

Skilled staff to deliver care

- The team consisted of nurses, an occupational therapist, doctor, support workers, speech and language therapist and a psychologist. The local authority provided social work support. Specialist assessments such as physiotherapy were carried out when required by outside agencies. This meant that patients had access to a variety of skills and experience for care and treatment.
- Staff completed an induction prior to commencing work on the wards. This included safeguarding, health & safety, information and data and MAYBO (conflict resolution and physical intervention) techniques. This was also made available to bank staff.
- Fourteen per cent of staff had received an annual appraisal of their work performance. Appraisals were left incomplete for many staff due to high turnover and new recruitment rates. Staff did not receive regular managerial supervision. Records showed 70% of staff had received supervision in the previous 12 months. This is below the provider supervision target of 80%. We saw four staff files containing staff supervision records, which showed one staff member, had supervision once in August and once in September 2015, prior to this they had not received supervision since September 2014. Another staff member had one record of supervision in November 2016 and none prior to this. One staff member had received no supervision and the last had three episodes of supervision since October 2015.
- Despite not recording through supervision or appraisal, senior staff addressed poor staff performance in a timely way. Managers carried out investigation and put support plans in place to improve the practice of staff members. Human resources supported managers to do this. There was a part-time dedicated human resources staff member working 30 hours a week.
- The provider had a policies' folder, which contained verification sheets signed by staff. Very few staff had signed to confirm they had read the policy and therefore might not be up to date with the provider's policies and procedures.
- The area director told us that all staff had access to the Danshell academy for specialist training and development.

Multi-disciplinary and inter-agency team work

- The provider held weekly multi-disciplinary team meetings attended by all disciplines, including non-registered support workers. We reviewed the minutes of MDT meetings for 3 months. We saw evidence of all attendees having input into updating records and discharge planning.
- Handovers took place at each shift change within the wards where each patient was discussed individually. Staff discussed issues related to patient care and outstanding actions that needed completion. Staff documented handovers so that they could refer to the information if required. There were daily 'flash' meetings where staff discussed plans for the day. Staff would discuss activity levels and decide how to manage resources for the day.
- Teams had effective working relationships. Collaborative working between psychology and occupational therapy improved the activities on the wards. The provider had good relationships with outside organisations such as social services and community care coordinators.

Adherence to the MHA and the MHA Code of Practice

Requires improvement

Wards for people with learning disabilities or autism

- The provider's training records showed that 43% of staff were up to date with Mental Health Act training. This was below the provider's target of 80%. However, despite this staff were able to demonstrate a good understanding of the Mental Health Act process.
- Staff attached capacity to consent to treatment forms to medication cards where necessary. We reviewed six medication records and found that consent to treatment forms were attached where appropriate for staff reference.
- We reviewed care records and saw evidence that patients had their rights under the Mental Health Act explained to them on admission and staff repeated this on a monthly basis.
- The Mental Health Act administrator provided support and legal advice for staff on implementation of the Mental Health Act and code of practice. Staff could access further advice from a centralised team in the provider's head office. Staff reported they would seek this support when required.
- Doctors granted some patients section 17 leave. We saw that the forms included frequency and duration of the leave authorised for each individual patient.
- Staff completed Mental Health Act documentation correctly. We looked at three sets of detention documents, which showed that documentation was complete. The Mental Health Act administrator audited mental Health Act records.
- Management had updated policies in line with the new code of practice. The provider's head office completed regular audits to ensure that the Mental Health Act was applied correctly.
- Patients had access to independent mental health advocate services and staff were clear on how to access and support engagement with the service. We saw posters in the reception area and on wards advertising this service.

Good practice in applying the Mental Capacity Act

- Training records showed that 46% of staff had completed The Mental Capacity Act and Deprivation of Liberty Act training. This was below the provider's target of 80%.
- Registered staff we spoke to had a good understanding of the Mental Capacity Act and Deprivation of liberty safeguards. Non-registered staff told us that they were not involved in mental capacity assessments. Staff could refer to the provider's The Mental Capacity Act policy, which included Deprivation of liberty safeguards if needed.
- Staff assessed patients' capacity and we saw evidence of this in the notes. Staff had completed Mental Capacity Assessments appropriately, with evidence given for the judgements reached. However, ten best interests decisions for one patient concluded that the patient did not have capacity in the area being considered but did not refer to any decision being made in the patient's best interest.
- We saw evidence that staff supported patients to make decisions, and staff told us that they held best interest decision meetings and recorded these on the electronic recording system at multi-disciplinary meetings.
- The Mental Health Act administrator offered support and legal advice on implementation of the Mental Capacity Act and Deprivation of liberty safeguards. It was also available from a centralised team in the provider's head office. Staff reported they would seek this support when required.
- The provider reported five Deprivation of liberty safeguards applications in the six months from 23 February 2016. There were four patients on Deprivation of liberty safeguards at the time of inspection. However, we saw one application was out of date and was awaiting the second opinion appointed doctor. We discussed this with the staff and it was felt that there was a geographical delay in response times from the second opinion appointed doctor service.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- Staff showed a good understanding of the individual needs of the patients. Staff were kind and compassionate in their interactions with patients.
- Patient told us that staff treated them with kindness dignity and respect. One patient told us that the staff were like his family.

Requires improvement

Wards for people with learning disabilities or autism

- Staff supported patients to attend their daily activities and their planned therapeutic programme, for example escorted leave and occupational therapy.

The involvement of people in the care they receive

- Patients did not always sign or have a copy of their care plan. We reviewed eight care records. The patients had signed none of the care plans. It was not clear in the records how staff document that they have given patients a copy of their care plan. One patient told us he was involved in his care plan. He did not want to keep it in his room, but could see it if he wanted to.
- The multi-disciplinary team told us that they always invited patients to the multi-disciplinary team meetings. The provider used easy read multi-disciplinary meeting forms for patients to complete prior to attending the meeting to give feedback to the team.
- Patients attended service user forum meetings supported by the occupational therapist.
- Eighteen patients and carers attended the Christmas meeting.
- Staff invited carers to attend the relatives' forum.
- We saw evidence of patient involvement in the recruitment of staff, for example being a part of the interview panel.

Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- At the time of inspection, there were 12 patients currently at Thors Park. The hospital is registered for 15 patients. Therefore, there were beds available for people in the catchment area.
- Bed occupancy was 79% for the period 1 April 2016 to 1 September 2016,
- The provider reported three out-of-area placements (to other providers in Lincolnshire, Birmingham and Leicestershire) in the last six months from 1 April 2016 to 1 September 2016. The provider did not provide a reason for these transfers.
- Staff did not routinely move patients between wards. However, staff moved one patient to the bespoke unit, as he was unable to tolerate living with others. Staff were planning to move him to another bespoke unit temporarily while the unit he currently occupied was repaired following damage.. Staff told us they would only facilitate this with the patients individual needs care planned and discussed at the multi-disciplinary meeting.
- The provider had two delayed discharges on Brightlingsea ward in the six months prior to inspection. This was because the clinical commissioning group were unable to find suitable step down placements.
- We observed proactive discharge planning in the multi-disciplinary meeting. Staff kept patients beds available for them to return to following leave. One patient told us how staff were supporting him to move on to supported living.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a full range of rooms and equipment to support treatment and care. There was an occupational therapy suite including an activity of daily living kitchen for assessments and interventions, a sensory room and large craft/activity room. Patients were receiving interventions as detailed in their care plans, for example in the occupational therapy kitchen to suit their individual needs and prepare for discharge. There were computers for the patients to use; display screen risk assessments were completed and patients were encouraged to use skype to talk with family and friends. The provider told us that they had secured money to provide a walk in poly-tunnel. They sourced this to enable the patients to become involved in horticultural activities and the provision of home-grown produce.
- There were quiet areas on the ward for patients to see visitors. Staff told us that patients would use the conservatory areas to see family and friends.
- The provider had a mobile phone in the office. Staff made this available to patients for private conversations.
- The hospital is set in a 30 acre site, and there was access to secure outside space for both wards.
- The hospital had a dedicated chef who provided a wide choice of meals to cater for individual dietary needs. Of

the four patients, we spoke with and five from the comment cards received, four patients told us that the food is good at the hospital. Patients had access to hot and cold drinks, and snacks throughout the day. Staff used pictorial menus so they could support patients to choose their meals. Staff also used these in cooking activities to source ingredients.

- Patients were able to personalise their bedrooms if they wished. Not all patients chose to do this.
- The provider had a seven day activity programme displayed in ward areas and in patient notes. The occupational therapy team would provide activities from Monday to Friday and ward staff would facilitate activities at weekends.

Meeting the needs of all people who use the service

- The provider had made adjustment for disabled access. All doors were wide enough to allow wheelchair access and there were ramps where necessary.
- Staff told us they supported patients to access information about local services, patients' rights and how to complain. The provider displayed information in ward areas and the main reception area for example local services and advocacy.
- The provider had access to an interpreter service. Patients could use interpreters for review meetings or other important meetings such as Mental Health Act tribunals.
- The provider supplied a wide choice of food to meet the dietary requirements of patients, including different religious and ethnic groups.
- There was access to spiritual support. The staff would support patients to attend a local church service. The provider could also access spiritual support from leaders of other religious groups such as Rabbi and Imam's.

Listening to and learning from concerns and complaints

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- The provider reported that there were six complaints received in the last twelve months. At the time of reporting all were upheld and none were referred to the Ombudsman. There were a further three complaints between 02 March and 02 April 2016; all three were partially upheld.
- Staff told us they should receive feedback from complaints within team meetings. We reviewed the minutes of 3 months team meetings and could not find evidence of feedback from complaints.
- Patients were aware of how to make a complaint and were supported by staff when this was needed.
- We spoke to a carer who had some concerns regarding specific areas, for example the care of the patient's clothes did not come up to her standard. However, she told us that when she raised a safeguarding concern because of his dietary needs, a safeguarding meeting was held, and the concerns she raised were being addressed.

Are wards for people with learning disabilities or autism well-led?

Requires improvement

Vision and values

- Staff told us they are aware of the provider's values to make a positive difference to people and their families by delivering personalised health and social care that helps them to achieve the things they want out of life. Staff believed that this was reflected in the care provided.
- The hospital published monthly newsletters for staff to update them on changes in the organisation.
- Most staff knew who the senior managers within the hospital were and reported that they were approachable and supportive. However, three staff told us they did not know who the senior managers within the organisation were and that they rarely attended the ward.

Good governance

- The managers had systems in place for monitoring mandatory training. Staff were alerted when their training was due for renewal. However, despite this compliance rates were still low.
- Managers did not have a system in place for monitoring supervision, subsequently staff compliance with supervision was low.
- Managers staffed shifts to the established levels of nurses, although at times the provider achieved this by using agency or bank staff.

Requires improvement

Wards for people with learning disabilities or autism

- Staff were able to maximise their time on direct care activities. Staff spent the majority of their time in the ward areas engaging with and supporting patients.
- Staff participated in clinical audits, for example, medication stock checks, clinical room audits, care plan and risk assessment audits. Hospital managers monitored these, reviewed, and reported them through the ward to board reporting system.
- Senior Managers did not discuss incidents at regional governance meetings. Whilst staff discussed incidents in team meetings, there was no evidence that themes and trends were identified at a senior level. We looked at clinical governance meeting minutes and incidents and lessons learnt were not standard agenda items. However, data submitted by the provider showed that steps had been taken to address complaints received. Following complaints from staff that there were not enough pin alarms, one-hundred of these had been purchased and a new system for recording their allocation had been put in place.
- Staff had input into the local risk register, which was linked to the provider's risk register. Staff were aware of the process for reporting risks.

Leadership, morale and staff engagement

- The service had a sickness rate of 5% for the past 12 months.
- Staff were aware of the whistle blowing policy. Staff told us that they would feel confident to raise issues without fear of victimisation.
- The provider had difficulty recruiting a new service manager between October 2015 to July 2016 causing disruption to the service and inconsistent leadership to the staff. However the provider's director of operation based themselves at the service and a peripatetic manager assigned to support the service until May 2016 so the service was not without appropriate management support. Following this period there was initial resistance to new leadership and poor practice was identified. Some of this accounted for the significant number of the leavers. However, this had now stabilised, staff morale was good and an active recruitment plan was in place with regular interviews taking place. The provider used a recruitment agency to vet potential employees.
- There were opportunities for leadership development. Staff told us there were opportunities to further their careers if they wished.
- There were two deputy ward manager posts which had been introduced and recruited into; these had two supernumery days a week, two days blended into the rota. Deputy ward managers were rostered on shift every other weekend.
- Staff were open and honest and explained to patients when things had gone wrong. We saw evidence of this within incident reports and complaint information.

Commitment to quality improvement and innovation

- The Award Scheme Development and Accreditation Network, which was designed to develop alternative education provision, accredited the hospital.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff receives regular supervision and an annual appraisal.
- The provider must ensure staff are up to date with mandatory training.
- The provider must ensure restraint and restrictive practices amounting to seclusion or segregation were recognised and recorded

The Provider must ensure that when patients' lack capacity to make their own decisions, mental capacity assessments give details of decisions made in the patient's best interest

Action the provider SHOULD take to improve

- The provider should ensure there is a more robust system for all staff to sign to say they have read policies.
- The provider should ensure patients are given a copy of their care plan and that this is documented in their records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider had not ensured that, where patients lack capacity to make decisions for themselves, decisions taken in their best interest were fully documented** **This is a breach of regulation 11 (1)(2)(3)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured all staff were up to date with mandatory training.** **This is a breach of regulation 12 (2) (c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider had not ensured that all practices amounting to seclusion or segregation were recognised, recorded and safeguarded in line with requirements set out in the Mental Health Act Code of Practice.** **This was a breach of Regulation 13(4)(b)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured that all staff were in receipt of supervision

The provider had not ensured that all staff were in receipt of up to date appraisal

This was a breach of Regulation 18(1)(2)(a)