Thors Park

Quality Report

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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	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

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

Overall summary

We rated Thors Park as good because:

- The provider ensured there were sufficient staff on duty for safe care and treatment of patients. The provider had significant vacancies for support workers; however, agency staff were block booked, where possible, to ensure continuity of care for patients. Data provided showed no shifts were left unfilled. New staff, including agency staff, received an induction to the service before working with patients. Staff were in receipt of mandatory training, clinical supervision and appraisals. The manager had introduced a new supervision model.
- We observed kind and compassionate interactions between staff and patients. Staff showed a good understanding of the individual needs of the patients and treated them with respect and dignity. Staff showed passion for their work with patients.
- Patients had access to advocacy services and staff involved families and carers in discussions around care and treatment. Staff supported patients to access information about local services, patients' rights and how to complain.
- Staff were aware of safeguarding procedures and made referrals when necessary for the protection of patients. Patients told us they felt safe in the service. Staff completed holistic and recovery focused care plans and positive behaviour support plans. Staff completed risk assessments on admission and updated regularly and after incidents. Staff knew how to report incidents and managers completed investigations. Staff were aware of their responsibilities under duty of candour and we saw evidence that these principals were followed, when required.
- Staff prescribed medication in accordance with National Institute for Health and Care Excellence guidelines. Medication was stored and administered appropriately and in accordance with the appropriate legal authority. Staff completed and stored Mental Health Act paperwork correctly.
- Staff completed capacity assessments in accordance with the Mental Capacity Act 2005 and held best interest decision meetings for significant decisions.
- The provider had a full range of rooms and equipment to support care and treatment for patients. Patients were able to personalise their bedrooms if they wished and had access to lockable storage within their bedrooms. The provider had a seven day activity programme displayed in ward areas and in patient notes. Patients had access to outside activities, such as a climbing wall and swimming. Work placements were also available.
- The service was well led at local and regional level. Senior managers demonstrated a commitment towards continual improvement and innovation and had worked hard to improve the culture of the hospital and morale of staff. The provider had a robust rolling audit programme to monitor the effectiveness of the service. The provider had ongoing plans for refurbishment at the hospital to improve the quality of the estate.

However:

- The provider had not fully completed the services ligature risk assessment. Staff did not have all the detail for the safe management of patients at risk of self-harm.
- The provider had not ensured the emergency equipment was fully accessible. The sink in the clinic room was stained and did not meet infection protection and control guidance. The provider had not ensured all emergency equipment was in good working order. One defibrillator did not have the required pads and the suction machine was broken.
- Staff had not ensured all areas of the hospital were clean and some damaged areas had not been repaired.
- Staff did not always fully complete records of physical health care monitoring for patients.

Summary of findings

- Patients remained in the service for long periods. The provider reported an average length of stay for patients of 1825 days.
- The provider did not always ensure all staff received feedback of outcomes of investigations from within the service or from other sites.

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	Good 	• 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

Contents

Good

Thors Park

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Thors Park

Oakview Estates Limited is the registered provider for Thors Park. Thors Park is an independent hospital that provides support for up to 14 men. At the time of the inspection, there were 12 men receiving care and treatment at the hospital.

Based in Thorrington, North East Essex, Thors Park provides support and treatment for men with learning disabilities and complex needs. The provider accepts patients who have additional mental and physical health needs, and those who have been detained under the Mental Health Act. The service comprises of three elements:

- Thorrington Ward is an eight bed service that provides assessment and intervention for men with learning disabilities, complex needs and behaviours.
- Brightlingsea ward is a four bed service for individuals who require support that is more intensive. There are four self-contained, bespoke apartments.
- The provider also has two bespoke single person apartments that provide a more independent living environment.

The CQC registers Thors Park to carry out the following legally regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The provider has a registered manager and controlled drugs accountable officer.

Thors Park has been registered with CQC since 28 November 2012. Since registration, there have been six inspections completed by CQC, the last of which was in December 2016. Following this inspection, the provider received an overall rating of requires improvement. The safe, effective and well led domains were rated as requires improvement. The caring and responsive domains were rated as good. During the last inspection, the following breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified:

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. Following this inspection, we found the provider had addressed this issue.

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment:

The provider had not ensured all staff were up to date with mandatory training. Following this inspection, we found the provider had addressed this issue.

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. Following this inspection, we found the provider had addressed this issue.

Our inspection team

The team that inspected the service comprised of one CQC inspection manager, two CQC inspectors, one specialist advisor and one expert by experience. An expert by experience is a person with knowledge of using services, or caring for someone who uses services

Summary of this inspection

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.

During the inspection visit, the inspection team:

- visited all wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with four patients' relatives
- spoke with the registered manager and compliance manager
- spoke with 14 other staff members; including doctors, nurses, occupational therapist
- psychologist, speech and language therapist and support workers
- looked at seven care and treatment records of patients
- looked at all medication prescription charts
- sought feedback from eight clinical commissioning groups
- 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.

What people who use the service say

We spoke with three patients and four family members during the inspection.

- Overall, patients told us they were happy in the service, felt safe and were well supported by the staff. All patients told us they had regular access to a doctor and a dentist.
- Two patients said there were not always enough staff and one patient and two family members told us that activities were sometimes cancelled when there were insufficient staff available.
- Two patients did not like the food, or felt there was limited choice. One patient told us the food was good.
- One patient told us he enjoyed the activities, such as walking, colouring and artwork. All patients told us their possessions were safe. Two family members told us their relatives' possessions had gone missing.
- Two family members told us the experienced and longer serving staff members had really detailed knowledge of how to care for their relative, but felt this did not always apply to agency or newer staff members. One family member told us staff were skilled at managing difficult patients and they felt safe when they visited the service.
- Three family members told us they were involved in the care and treatment decisions and that management were responsive to their requests for information. Managers organised conference calls to aid communication when needed.

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 provider had not fully completed the ligature risk assessment. Staff did not have all the detail for the safe management of patients at risk of self-harm.
- The provider had not ensured the emergency equipment was fully accessible. The sink in the clinic room was stained and did not meet infection protection and control guidance.
- The provider had not ensured all emergency equipment was in good working order. One defibrillator did not have the required pads and the suction machine was broken.
- Staff had not ensured all areas of the hospital were clean and some damaged areas had not been repaired.
- The provider had high vacancy rates. Vacancy rates for support workers were particularly high.

However:

- The provider ensured safe staffing levels for care and support of patients.
- Staff were aware of safeguarding procedures and made safeguarding referrals for the protection of patients when needed.
- Staff were in receipt of mandatory training in accordance with the provider's policy.

Are services effective?

Good

We rated effective as good because:

- Staff completed care plans that were holistic and recovery focused. These covered a range of needs including personal care needs, diet and nutrition, and activities. Staff reviewed these regularly during patient's care review meetings.
- Staff followed National Institute for Health and Care Excellence guidelines for prescribing medication.
- Staff completed care plans that were holistic and recovery focused. These covered a range of needs including personal care needs, diet and nutrition and activities.
- Staff received clinical supervision in accordance with the provider's policy.
- Ninety-five per cent of were in receipt of an annual appraisal.

Summary of this inspection

- Staff prescribed medication in accordance with National Institute for Health and Care Excellence guidelines. Medication was stored and administered appropriately and in accordance with the appropriate legal authority.
- Staff received training in the Mental Health Act and Mental Capacity Act.
- Staff completed and stored Mental Health Act paperwork correctly.
- Staff completed capacity assessments in accordance with the Mental Capacity Act and held best interest decision meetings for significant decisions.
- Teams had effective working relationships. Staff invited outside professionals to care and treatment reviews and documented the discussions and decisions in the patient records.

However:

- Staff did not always fully complete records of physical health care monitoring for patients.

Are services caring?

Good

We rated caring as good because:

- We observed kind and compassionate interactions between staff and patients. Staff showed a good understanding of the individual needs of the patients and treated them with respect and dignity. Staff showed passion for their work with patients.
- Families told us they were involved in their loved one's care and treatment.
- Staff invited carers to attend the relatives' forum.
- Patients had access to advocacy services and we saw posters displaying contact information on wards.

Are services responsive?

Good

We rated responsive as good because:

- The provider had a full range of rooms and equipment to support care and treatment for patients.
- Patients were able to personalise their bedrooms if they wished.
- Patients had access to lockable storage within their bedrooms. Patients were able to hold their own keys, subject to risk assessment.
- The provider had a seven day activity programme displayed in ward areas and in patient notes.
- Patients had access to outside activities, such as a climbing wall and swimming. Work placements were also available.

Summary of this inspection

- Staff supported patients to access information about local services, patients' rights and how to complain.

However:

- Patients remained in the service for long periods. The provider reported an average length of stay for patients of 1825 days.

Are services well-led?

Good

We rated well led as good because:

- The service was well led at local and regional level.
- There was a commitment towards continual improvement and innovation.
- Senior managers had worked hard to improve the culture at the hospital and improve the morale of staff.
- Senior staff ensured safe staffing levels on the wards, despite significant substantive staff vacancies.
- The provider had recently improved systems for staff compliance with clinical supervision. The manager had introduced a new supervision model.
- The provider had a robust rolling audit programme to monitor the effectiveness of the service.

However:

- The provider did not always ensure all staff received feedback of outcomes of investigations from within the service or from other sites.

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.

- At the time of the inspection, ten patients were receiving care and treatment under the Mental Health Act.
- The provider required staff to complete mandatory training in the Mental Health Act. The provider supplied their training matrix, which showed 89% of staff had received this training.
- Staff demonstrated a good understanding of the Mental Health Act and Code of Practice.
- Staff supported patients to access the independent mental health advocate. An Independent Mental Health Advocate(an IMHA) is someone who is specially trained to work within the framework of the Mental Health Act to meet the needs of patients. Staff were clear on how to access the service for patients. We saw posters across the site advertising this service.
- The Mental Health Act manager completed audits on the application of the Mental Health Act and Code of Practice.
- Doctors granted patients section 17 leave, where appropriate and completed paperwork to include frequency and duration of the leave.
- Staff completed records of patients' consent to treatment and recorded these in patient records. Staff attached copies of consent to treatment forms to medication charts to ensure medication was administered under the appropriate legal authority.
- Staff read patients their rights under the Mental Health Act. We saw evidence that patients had their rights explained to them on admission and routinely thereafter.
- Staff completed detention paperwork correctly and kept copies in patient notes for staff reference.
- The provider had updated Mental Health Act policies in line with the new code of practice. A copy of the code of practice was available for staff reference.

Mental Capacity Act and Deprivation of Liberty Safeguards

CQC have made a public commitment to reviewing provider adherence to MCA and DoLS.

- At the time of inspection, two patients were receiving care and treatment under deprivation of liberty safeguard authorisations (DoLS).
- The provider required staff to complete mandatory training in the Mental Capacity Act. The provider supplied their training matrix, which showed 90% of staff had received this training.
- The provider ensured independent mental capacity advocates were available to support patients who lacked capacity. Independent mental capacity advocates are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options.
- 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 Act manager responsible for the monitoring of adherence to the Mental Capacity Act within the service.
- Registered staff we spoke to had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. 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.
- Staff supported patients to make decisions. The speech and language therapist supported patients with their communication difficulties when needed.
- Where patients lacked capacity, best interest decision meetings took place for significant decisions. However, some best interest documentation lacked detail of the specific decision being considered.

Detailed findings from this inspection

- The Mental Health Act manager 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 one Deprivation of Liberty Safeguards application between May 2017 and November 2017.

Overview of ratings

Our ratings for this location are:

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

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- There were good lines of sight across the hospital. Staff were able to observe patients.
- The provider had installed CCTV in some areas. The provider had a CCTV policy and appropriate signage in place. Staff could monitor CCTV from the ward office; however, routine monitoring only occurred following incidents.
- The provider did not have a fully completed ligature risk assessment. A ligature risk is any point to which a patient could attach an implement for the purpose of self-strangulation. The provider used an assessment audit tool to identify and manage ligature anchor points within the service, which identified all ligature anchor points. However, we found the assessment did not detail mitigation or management for all risks identified. For example, the provider had a works required action plan that showed plans to update handles in the conservatories to an anti-ligature fitting. These plans were not recorded on the ligature risk assessment. The bespoke units on Brightlingsea ward had no identified actions or management plans included in the assessment, meaning the assessment was incomplete. However, staff managed the risks within the environment with individual risk assessments for patients. At the time of the inspection, there were no patients receiving care and treatment with identified risk of self-harm.
- The provider only accepted male patients, and therefore complied with the Department of Health's guidance for same sex accommodation.
- The provider had a fully equipped clinic room. However, the handwashing sink was dirty and contained lime scale. This was not compliant with infection protection and control guidelines. Staff monitored the fridge and room temperature on a daily basis.
- The provider did not have quick access to all emergency equipment. Emergency equipment was stored in two different areas. This might cause a delay for staff accessing equipment in an emergency. Staff did not have access to oxygen saturation kits within the emergency grab bag and the suction machine had been broken since August 2017. The defibrillator within the occupational therapy room did not have the required pads present, meaning that it could not be used in an emergency. Adefibrillatoris an electrical device that provides a shock to the heart when there is a life-threatening arrhythmia present.
- Staff had not completed regular checks of the first aid kit within the occupational therapy room to ensure the contents were within date and suitable for use. The medication fridge was not locked on inspection and dust and debris was seen behind the fridge. Records showed staff checked equipment on a weekly basis; however, these issues had not been identified.
- The medication management policy had not been reviewed and expired in June 2017. We raised this with the provider. The provider ensured the policy was immediately updated.
- The provider did not have seclusion facilities.
- Overall, staff regularly maintained and cleaned the environment and equipment. We reviewed the cleaning records, which showed regular cleaning was completed

across the hospital. All cleaning products were securely locked away in accordance with the control of substances hazardous to health regulations (2002). However, staff had not ensured that all areas of the hospital were clean. For example, the sensory room was seen to have dust across window areas and there were visible scuffmarks on some paintwork.

- The provider was completing some refurbishment during the inspection. The provider had a detailed works required action plan, which showed maintenance required within the hospital, with projected dates for completion. Most actions had been recently completed, or were in progress, including a deep clean of some patient bathroom facilities and an update to one conservatory.
- Staff completed environmental audits, which highlighted areas of concern within the hospital. The provider employed two maintenance operatives. Staff used an onsite reporting system to report when repairs were needed and other maintenance issues. However, we found one toilet had a broken window, the sluice had a blocked sink, and a window in a corridor had a broken window restrictor. There was a risk a patient could get out through this window. This was raised with senior managers for urgent action during the inspection.
- Staff adhered to infection control principles including handwashing. Staff had access to the appropriate personal protection equipment, such as gloves and aprons.
- Staff had personal alarms across all wards. Reception staff issued personal alarms to visitors to ensure their safety.

Safe staffing

- The provider reported a total number of staff working within the service, as at November 2017, of 89, of which 68 posts were for registered nurses and nursing assistants. Data provided showed 39 substantive staff left between October 2016 and November 2017, representing 60%. The provider reported a current vacancy rate for all substantive staff of 57%.
- Data provided showed at 29 October 2017, the provider had an establishment for registered nurses of six, with one vacancy (16%). The establishment for nursing assistants was 62. For the same period, the provider reported 32 nursing assistant vacancies, representing a shortfall of 52%.
- The provider had a rolling recruitment programme. Two new support workers had been recruited and were currently completing induction and shadowing of staff in the service.
- The provider ensured there was sufficient staff to provide safe care and treatment for patients. The manager adjusted staffing levels to meet patient needs. Where vacancies existed, the provider used regular bank and agency staff to ensure safe staffing levels on the wards. Where possible, the provider block booked agency staff to ensure continuity of care for patients. The provider ensured all agency staff undertook a service induction to familiarise them with the patients and the running of the service.
- Data provided between 13 August 2017 and 29 October 2017 showed 1480 shifts filled by bank and agency staff. No shifts were left unfilled.
- The provider deployed sufficient staff to ensure patients had time with their named nurse. Staff and most patients told us activities were rarely cancelled due to staffing levels.
- The provider deployed sufficient staff to safely carry out physical interventions.
- The provider had an on-call consultant rota to ensure a doctor could attend the ward in an emergency. Staff called the emergency services for medical emergencies.
- The provider supplied data that showed a staff sickness rate of 4.3% for the year to November 2017.
- Staff were up to date with mandatory training. The provider used a training matrix to record and track compliance with training. At the time of the inspection, overall compliance with training was 86%, against the provider's target of 80%. However, no staff had completed first aid training.
- The provider had a dedicated team of trainers who provided face-to-face training to the workforce. Some e-learning courses were undergoing transformation to face-to-face training, following requests by staff.

Assessing and managing risk to patients and staff

- The provider reported no incidents of seclusion or long-term segregation of patients between June 2017 and November 2017.
- The provider reported 17 incidents of restraint, involving two patients between June 2017 and November 2017. No incidents involved staff placing patients in the prone

position (prone restraint occurs when a patient is pinned on a surface and is physically prevented from moving out of this position). Staff told us they used restraint techniques as a last resort.

- Over the same period, the provider reported no incidents of restraint resulting in the administration of rapid tranquilisation. (Rapid tranquillisationoccurs when medicines are given to a patient who is very agitated or displaying aggressive behaviour to help quickly calm them).
- Staff received training in physical interventions (restraint). At the time of the inspection, 97% of eligible staff had completed physical intervention training and all staff had completed their breakaway training.
- We reviewed seven care and treatment records. Staff had completed risk assessments on admission and reviewed them regularly during care review meetings or as required following an incident or change in risk.
- Staff completed personal emergency evacuation plans for all patients. This ensured staff were aware of how to safely evacuate patients in the event of an emergency.
- We did not observe any blanket restrictions at the hospital. The term 'blanket restrictions' refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application.
- The provider had a policy for safe and supportive observations. Staff used different levels of observation dependent on the level of risk. Staff reviewed observation levels regularly and during multi-disciplinary team meetings.
- The provider had a policy for searching patients. Staff searched patients upon return from leave if a patient was at risk of bringing contraband into the hospital.
- Staff received training in safeguarding adults and children. Ninety percent of staff were trained in safeguarding adults and children. Staff we spoke to knew how to make a safeguarding alert and were able to describe what would be a safeguarding concern.
- From November 2016 to November 2017, staff reported 24 safeguarding concerns to the local authority for investigation.
- Overall, there were good medicines management procedures in place. We reviewed all patient medication prescription charts, which showed staff were recording the dispensing of medication appropriately. Medication was stored in a locked cupboard with a separate cupboard for controlled drugs.
- Staff completed regular checks of the clinic room to ensure medication was stored and managed in line with Nursing and Midwifery Council (NMC) guidelines. However, one medication used to treat diabetic patients with very low blood sugars was not suitable for use due to a broken seal. We raised this urgently with senior staff.
- The provider used a local pharmacy for medication reconciliation. The pharmacy provided prescriptions following liaison with the nursing team and the GP. The pharmacy also completed audits of the clinic rooms and medication practice and produced action plans. We reviewed the last pharmacy audit completed in September 2017, which identified a number of omissions and concerns. The audit showed a timescale for completion of 31 October 2017, however there was no record that staff had completed the actions. The provider completed detailed internal medication management audits and the results were discussed in local and regional governance meetings.
- The provider had no dedicated area for children to visit. The manager advised that if children wished to visit, this would be facilitated in the administration area. The manager told us there were plans to convert an unused room into a family room. However, this was not recorded on the works required action plan.

Track record on safety

- The provider reported six serious incidents in the year to November 2017. The most frequently occurring type of serious incident was 'abuse/alleged abuse of adult patient by staff' (five incidents) followed by 'slips/trips/falls' (one incident).
- The provider reported monthly incident statistics to service managers, divisional managing directors, and the provider's board of directors.
- The provider gave examples of where the service had learned from incidents. For example, driver shields had been recently re-installed in their patient transport, following an adverse incident.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents. Agency staff completed a paper report, which qualified

staff uploaded onto the electronic incident recording system. Managers would then review and complete investigations. The nurse consultant oversaw some incident investigations and all incidents related to medication management or administration. Staff were given extra training, if required, following medication errors. All completed incident investigations were seen by the compliance manager before sending to the provider's board of directors.

- Managers shared lessons learnt from incidents were via quality and governance meetings at service, regional and group level. Lessons learnt and good practice were shared across regions and wider within the company.
- We were not assured that all staff received information for lessons learned to inform practice.
- Reporting staff received feedback from incidents via the electronic reporting system. Managers told us they gave feedback from incidents at staff meetings. We reviewed team meeting minutes from September 2017 to January 2018, which showed evidence of discussion concerning incidents in three meetings. A standard agenda was available, but not always used to focus or record discussions related to incidents. Incidents were a standard agenda item at the weekly MDT meetings and were discussed during morning 'flash' meetings. However, not all staff were present during these meetings. Staff received alerts via email detailing incidents from other sites. However, senior staff told us that alerts did not go to all staff, for example housekeepers.
- Staff were not always offered timely debriefs following incidents. The manager had identified this shortfall and had plans to ensure that debriefs occurred as soon as practical after an incident.
- The provider reviewed all incident data at service led clinical and governance meetings.

Duty of Candour

- Duty of candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident and providing reasonable support, providing truthful information and an apology when things go wrong.
- The provider had an up to date policy for duty of candour. The provider advised that staff received training in duty of candour at induction and, where applicable, during training for the care certificate.
- Staff we spoke with told us they were aware of the provider's policy and they were aware of their responsibilities concerning being open and honest when things had gone wrong.
- We reviewed recent complaints and saw evidence of staff adherence to the principals of duty of candour, where required.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed seven care and treatment records for patients.
- Staff completed a thorough assessment of patients' needs after admission. Staff used information gathered during this assessment to formulate a care plan.
- The psychologist completed positive behaviour support plans for patients, with input from the nursing staff, occupational therapist and speech and language therapist. We reviewed seven records and found the positive behaviour support plans to be robust, with clear guidance on how staff should support patients.
- Staff completed care plans that were holistic and recovery focused. These covered a range of needs including personal care needs, diet and nutrition and activities. Staff reviewed these regularly during patients care review meetings. Staff offered patients a copy of their care plan and recorded when patients had been unable or unwilling to sign their plans.
- Staff completed physical health checks on admission and completed care plans when needed to manage physical health concerns. Staff monitored physical health needs and updated records. However, we found some gaps in recording.
- The provider used an electronic recording system to update patient records. Staff also kept paper records. All staff had access to the electronic recording system including bank and agency staff. Staff kept patient records securely in the ward office.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidelines when prescribing medication. Staff told us they followed National Institute for Health and Care Excellence guidance on the use of antipsychotic medication. We reviewed the patients' prescription charts and saw that medical staff prescribed anti-psychotic medication in line with NICE guidance.
- The provider followed National Institute for Health and Care Excellence guidance for delivery of safe care and treatment. For example, National Institute for Health and Care Excellence (2015) on challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges, and epilepsies: diagnosis and management (2012).
- The speech and language therapist used a variety of assessment tools, including the children apraxia of speech (CAS) and the test for reception of grammar.
- The clinical psychologist provided psychological interventions recommended by National Institute for Health and Care Excellence. For example, a modified version of cognitive behavioural therapy, anxiety management, and interpersonal skills. Outcome measures included clinical outcomes in routine evaluation, which is an outcome-rating tool, neuropsychological testing, and functional analysis.
- Patients had access to physical health care. No patients were registered with a local GP practice; however, the provider used a private GP who attended the service regularly. Staff accessed physical healthcare specialists for patients via referral from the GP.
- Staff used recognised rating scales such as health of the nation outcome scales (HoNOS), outcomes star and LUNSERS (The Liverpool University Neuroleptic Side Effect Rating Scale, LUNSERS is self-rating scale for measuring the side-effect of antipsychotic medications. Staff completed these with patients.
- Staff completed clinical audits such as clinic room checks, care plan and risk assessment audits.
- The provider employed a regional nurse consultant who took the lead on the rolling audit programme. The provider completed an annual quality of delivery report, mapped to the CQC domains and Health and Social Care regulations. We reviewed the latest action plan, dated November 2017 and saw all actions were either completed, or ongoing.

Skilled staff to deliver care

- The team consisted of a consultant psychiatrist, nurses, an occupational therapist, support workers, speech and language therapist, activity co-ordinator and a consultant psychologist. The local authority provided social work support. Outside agencies completed specialist assessments, when required, such as physiotherapy. This meant that patients had access to a variety of skills and experience for care and treatment.
- The provider had a link infection control nurse who provided support for infection control issues to staff.
- All staff completed an induction prior to commencing work on the wards. This included safeguarding, health & safety, information and data, conflict resolution and physical intervention techniques. The provider told us all bank and block booked agency staff completed the provider's induction programme prior to working with patients. We saw evidence of this in records.
- Staff received training in positive behaviour support. Twenty-eight staff, including agency staff, had recently attended a training day based around case studies.
- Staff had access to specialist training. Specialist training was agreed by the manager and arranged via the regional training manager.
- The provider required all eligible support workers to complete the care certificate within three months of employment. The care certificate was officially launched in March 2015. It aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. At the time of the inspection, two staff had completed and five was undergoing this training.
- Where eligible, support staff completed a National Vocational Qualification (NVQ) at level two or above. At the time of the inspection, 16 staff held a NVQ level two (30%) 11 staff held an NVQ level three (21%) and two staff held a NVQ level four (4%). Therefore, 55% of the support staff held an NVQ qualification related to their role. Two staff were undertaking their nurse training to become registered nurses.
- Staff had not completed leadership training. At the time of inspection, the provider was waiting for course dates to be agreed for eligible staff.
- The speech and language therapist had used a case study approach to deliver communication passport training to staff.

- The provider offered a preceptorship programme to all newly registered nurses to enable them to consolidate their learning into practice and confidently take on the role and responsibilities of a registered nurse.
- Staff received clinical supervision in accordance with the provider's policy. Data provided as at November 2017 showed only 46% of staff were in receipt. However, during the inspection we reviewed the compliance matrix for 2017 and 2018, which showed an improvement in supervision compliance over the past few months. All staff were in receipt of supervision in line with the provider's policy. Staff we spoke to confirmed they received supervision and additional support when required.
- All staff (95%) were in receipt of an annual appraisal.
- Senior staff addressed poor staff performance in a timely way. Managers carried out investigations and, where necessary, put support plans in place to improve the practice of staff members. Human resources supported managers to do this. Data provided showed seven staff members had been suspended from the service on disciplinary grounds since September 2016. Six of these were support workers.

Multi-disciplinary and inter-agency team work

- The provider held weekly multi-disciplinary team meetings attended by all disciplines. We reviewed the minutes of MDT meetings for 3 months and saw meetings followed a set agenda, which included discussions around incidents, medication effectiveness, observation levels, care plans and care and treatment reviews, physical healthcare requirements, occupational reviews, psychological updates, speech and language updates and review of Mental Health Act compliance.
- 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. Staff held daily 'flash' meetings where staff discussed plans for the day, including activity levels and resource management.
- Teams had effective working relationships. Staff invited outside professionals to care and treatment reviews and documented the discussions and decisions in patient records.
- The provider had good relationships with outside organisations such as social services, the local GP and community care coordinators.

Adherence to the MHA and the MHA Code of Practice

- At the time of the inspection, ten patients were receiving care and treatment under the Mental Health Act.
- Eighty-nine per cent of staff had received training in the Mental Health Act.
- Staff demonstrated a good understanding of the Mental Health Act and Code of Practice.
- Staff supported patients to access the independent mental health advocate. An Independent Mental Health Advocate(an IMHA) is someone who is specially trained to work within the framework of the Mental Health Act to meet the needs of patients. Staff were clear on how to access and support engagement with the service. We saw posters across the site advertising this service.
- The Mental Health Act manager completed audits on the application of the Mental Health Act and Code of Practice.
- Doctors granted patients section 17 leave, where appropriate and completed paperwork to include frequency and duration of the leave authorised for each individual patient.
- Staff completed records of patients' consent to treatment and recorded these in patient records. Staff attached copies of consent to treatment forms to medication charts to ensure medication was administered under the appropriate legal authority.
- Staff read patients their rights under the Mental Health Act. We saw evidence that patients had their rights explained to them on admission and routinely thereafter.
- Staff completed detention paperwork correctly and kept copies in patient notes for staff reference.
- The provider had updated Mental Health Act policies in line with the current code of practice. A copy of the code of practice was available for staff reference.

Good practice in applying the MCA

- At the time of inspection, two patients were receiving care and treatment under deprivation of liberty safeguard authorisations (DoLS).
- Ninety per cent of staff had received training in the Mental Capacity Act.
- The provider ensured independent mental capacity advocates were available to support patients who

Good

Wards for people with learning disabilities or autism

lacked capacity. Independent mental capacity advocates are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options.

- 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 Act manager responsible for the monitoring of adherence to the Mental Capacity Act within the service.
- Registered staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. 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.
- Staff supported patients to make decisions. The speech and language therapist supported patients with their communication difficulties when needed.
- Where patients lacked capacity, best interest decision meetings took place for significant decisions. However, some best interest documentation lacked detail of the specific decision being considered.
- The Mental Health Act manager 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 one Deprivation of Liberty Safeguards application in the six months to November 2017.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- We observed kind and compassionate interactions between staff and patients. Staff showed a good understanding of the individual needs of the patients and treated them with respect and dignity. Staff showed passion for their work with patients.
- 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

- Staff invited patients to the multidisciplinary team meetings. Families told us they were involved in their relative's care and treatment.
- The provider used easy read multidisciplinary meeting forms for patients to complete prior to attending the meeting to give feedback to the team.
- The doctor met with patients outside of the multidisciplinary meeting, if this was their preference.
- Patients had access to an advocacy service.
- The provider held monthly community meetings on the wards. Staff discussed the outcomes during the morning flash meetings.
- Patients attended service user forum meetings supported by the occupational therapist.
- Staff invited carers to attend the relatives' forum.
- Patients had access to advocacy services and we saw posters displaying contact information on wards.

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 receiving care and treatment at the hospital. The hospital is registered for 15 patients. Therefore, there were beds available to admit patients.
- Patients could access the service following a referral, assessment and funding agreement. At the time of the inspection, patients within the service received funding from nine different clinical commissioning groups.

Good

Wards for people with learning disabilities or autism

- The provider supplied data for bed occupancy, which showed 95% for the six months to November 2017. Two patients had been discharged, one in September 2017 and one in October 2017.
- The provider reported one delayed discharge for a patient from January 2016 to November 2017. This was due to a delay in identification of an appropriate placement for the patient.
- The provider reported an average of 13 days from initial referral to assessment for patients referred to the hospital. The provider reported an average length of stay of 73 days, for patients discharged over the year to 31 October 2017. For current patients, the average length of stay was 1825 days.
- We observed proactive discharge planning in the multidisciplinary meeting and notes from the care and treatment reviews. However, the provider reported significant difficulties in locating suitable placements when patients were ready for discharge.
- One patient told us he had been sent videos of possible future placements to make the transition easier. Another patient had been able to view the architect's plans for his upcoming placement and had chosen the colours for the walls. Staff had purchased a slow cooker and were in the process of teaching him how to use it in preparation for his discharge.
- Staff kept patients beds available for them to return to following periods of authorised leave.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a full range of rooms and equipment to support care and treatment for patients. There was a life skills kitchen for people wanting to prepare or cook food for themselves or their visitors, a large art room where patients could enjoy a range of creative table-top crafts, in addition to a games room, an IT room, and a sensory room.
- All patient bedrooms had en-suite facilities.
- Patients had access to their bedrooms at all times. Staff kept bedrooms locked, however patients could hold their own keys subject to risk assessment. At the time of the inspection, three patients were in possession of bedroom keys. Staff opened bedroom doors on request.
- Patients were receiving interventions as detailed in their care plans, for example staff supported patients to learn skills in the occupational therapy kitchen to prepare for discharge.
- Patients had access to computers. Staff completed display screen risk assessments and patients were encouraged to use skype to talk with family and friends.
- There were quiet areas on the ward for patients to see visitors.
- The provider had a mobile phone in the office. Staff made this available to patients for private conversations.
- Patients had access to outside space. The hospital was set in a 30-acre site, and there was access to secure outside space for both wards.
- Overall, the patients and family members we spoke with told us the food was of good quality.
- 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.
- Patients were able to personalise their bedrooms if they wished.
- Patients had access to lockable storage within their bedrooms. Patients were able to hold their own keys, subject to risk assessment.
- The provider had a seven day activity programme displayed in ward areas and in patient notes. The occupational therapy team provided activities from Monday to Friday and ward staff facilitated activities at weekends. Patients had access to a wide range of activities, including outside activities, such as a climbing wall, swimming pool, and work placements. One patient was working with Essex Wildlife Trust nature reserve.

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.
- The provider had an assisted bathroom, with a hoist for use when needed.
- Staff 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. Patients had access to information in easy read format.
- The provider did not display information leaflets in a variety of languages. However, they could access these if needed.

Good

Wards for people with learning disabilities or autism

- 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.
- One staff member was completing training in Makaton and the speech and language therapist was due to start training. Makaton is a language programme designed to provide a means of communication to individuals who cannot communicate efficiently by speaking.
- 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 a Rabbi and an Imam. The hospital did not have a multi-faith room on site.

Listening to and learning from concerns and complaints

- The provider reported that there were 15 complaints received in the 12 months to November 2017. Six of the complaints were upheld and none were referred to the ombudsman.
- Staff told us they should receive feedback from complaints within team meetings. We reviewed the minutes of team meetings between September and January and found only one meeting contained information related to complaints. Complaints were not a standard agenda item. We were not, therefore, assured that outcomes from complaints were routinely shared with staff for learning. The manager advised that she was aware of this and had plans to include complaints in team meeting agendas.
- Patients were aware of how to make a complaint and were supported by staff when this was needed. Posters showing patients how to complain were available on wards and in easy read leaflets.
- In the year to November 2017, the provider received two compliments.

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

Good

Vision and values

- The provider had a key set of visions and values for the service.
- Staff told us they were 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 newsletters for staff to update them on changes in the organisation.
- Staff knew who the senior managers within the hospital were and reported that they were approachable and supportive.

Good governance

- The provider had good systems for monitoring the effectiveness of the service.
- The provider had systems in place for monitoring mandatory training. Staff were alerted when their training was due for renewal. Staff compliance with mandatory training was 86%.
- Staff received clinical supervision in line with the provider's policy. The provider had recently improved systems for staff compliance with clinical supervision. The manager was using a new supervision model.
- The service had high vacancy levels for support workers. However, the provider utilised block booked agency staff or bank staff to ensure safe staffing levels on wards.
- 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 reported incidents and complaints using the provider's electronic incident reporting system.
- Staff participated in clinical audits, for example, medication stock checks, clinical room audits, care plan and risk assessment audits.
- 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.

Good

Wards for people with learning disabilities or autism

- The provider followed safeguarding procedures and maintained contact with the local authority during investigations. However, senior staff reported it was difficult to get updated information from the local authority.
- The provider ensured that Mental Health Act and Mental Capacity Act policies and procedures were up to date and staff followed the appropriate legal processes. The provider ensured staff were up to date with mandatory training in both Mental Health Act and Mental Capacity Act.
- The provider had not updated all policies in accordance with review dates. Medication management, complaints, privacy and dignity, and CCTV policies were all out of date.
- The provider monitored the effectiveness of the service via a rolling audit programme and a quality development review report. Hospital managers, the regional nurse consultant and the director of quality monitored results. Results were passed to the organisation's board. Where compliance fell below 75%, the provider repeated the audit within a three-month period. Staff completed action plans with timeframes for completion identified. However, not all actions were signed as completed within agreed timescales. The provider had recently transferred audit reporting from paper to electronic records and some information had not been uploaded. At the time of inspection, data provided showed 91% across the QDR reporting system.

Leadership, morale and staff engagement

- Senior managers had worked hard to address the culture at the hospital and to improve staff morale. Staff we spoke with told us they were well supported by management.
- We observed good working relationships and morale amongst the staff we spoke with. Teams worked well together across the site.
- The provider had a sickness rate of 4.3%.
- The provider reported no current bullying or harassment investigations.
- Staff were aware of the provider's policy for whistleblowing and told us they felt confident to raise concerns without fear of victimisation.
- Staff were familiar with the principals of duty of candour and knew how to access the policy if needed.
- Staff gave feedback via their staff survey. We reviewed the latest staff survey results from December 2017, which identified areas for improvement. This included: job satisfaction, health and wellbeing, incidents and safeguardings, training and development and appraisals and supervision. Staff had discussed these results during team meetings.
- The provider had experienced difficulties in retaining a registered manager for the service. However, a new registered manager was now in post, following successful registration with CQC.

Commitment to quality improvement and innovation

- The provider did not identify its membership to any accreditation schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the ligature risk assessments include clear plans for how staff should manage risks across all areas.
- The provider must ensure staff have quick access to emergency equipment.
- The provider must ensure all emergency equipment is in good working order.
- The provider should ensure all areas of the hospital are kept clean.
- The provider must ensure all medication is safe for use.
- The provider must ensure all repairs are completed in a timely manner.

Action the provider SHOULD take to improve

- The provider should ensure that physical healthcare monitoring is fully completed in patient records
- The provider should ensure staff receive feedback on outcomes from incidents and complaints to inform their practice.
- The provider should ensure staff receive timely debriefs after incidents.
- The provider should ensure that actions identified from medication audits are completed and documented.
- The provider should ensure that all policies are regularly reviewed and updated.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not fully completed the ligature risk assessment. Staff did not have all information needed for the safe care and treatment of patients at risk of self-harm or suicide. • The provider had not ensured quick access to all emergency equipment. Some emergency equipment was not in working order. This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The sink in the clinic room was stained and not compliant with infection prevention and control standards. • Some areas of the hospital were not clean. • The provider had not ensured that timely repairs were completed for all damaged areas or equipment. This was a breach of regulation 15.