Thors Park

Quality Report

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Date of inspection visit: 17 and 18 September 2015
Date of publication: 19/01/2016

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:

- Risk assessments were comprehensive and reviewed regularly and if patients risk levels changed.
- Care plans were up to date, risk related, holistic and recovery focused.
- Staff appropriately reported all incidents.
- There were no episodes of prone restraint used on patients. Managers staffed shifts to the established levels of nurses: although these levels were at times achieved by using agency or bank staff.
- Senior staff had an active recruitment process in place.
- Staff interacted with patients in a caring and respectful manner. They told us they wanted to provided good quality care for patients.
- Weekly activity programmes were available to patients.
- The provider supported and trained patients to become experts by experience so that they could work with staff to complete audits.
- The service had a range of rooms and equipment – including a dedicated occupational therapy suite with a sensory room.
- Staff participated in clinical audits and used information from these audits to improve the service and outcomes for patients.
- Managers had access to key performance indicators to gauge team performance and compare against other services.
- Managers held debrief sessions and staff meetings to share outcomes of incidents, complaints and patient feedback.

However:

- Ligature and environmental risk assessments were conducted, but no action was taken to minimise assessed risks to patients.
- Cleaning records were not fully completed.
- Ensuite bathrooms were dirty, stained and had a musty odour.
- The paintwork looked tired and worn and the conservatory had missing window handles.
- Patients on Brightlingsea ward spent long periods of time in isolation for significant periods. This practice constituted long-term segregation.
- Nurses did not complete seclusion reviews and checks to safeguard patients in line with the Mental Health Act code of practice.
- Forty-two percent of staff were not up to date with mandatory training.
- The service had 28 staff vacancies.
- Staff supervision records were not fully completed and showed that not all staff received monthly supervision.

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 	Start here...

Summary of findings

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Good

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 12 men. There are two 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 delivers 24-hour care and support within four self-contained apartments. The service offers a structured and therapeutic environment and is for individuals who require more intensive support than is provided in Thorrington ward.

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

The commission last inspected Thors Park in December 2013 and found it to be compliant across the five assessed outcomes inspected.

Our inspection team

Team leader: Sarah Duncanson

The team that inspected Thors Park consisted of two CQC inspectors, a Mental Health Act reviewer, a nurse and a social worker. All team members had recent mental health service experience.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and perceptions of the quality of care and treatment at Thors Park.

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?

During this inspection visit, the inspection team:

- Visited Thors Park's two wards, reviewed the quality of the ward environments and observed how staff cared for patients
- Interviewed the registered manager and deputy manager
- Reviewed four staff files
- Looked at seven patient case records
- Interviewed six staff members – a consultant psychiatrist, a nurse, a psychologist, an activity coordinator and an occupational therapists
- Spoke to one patient (access to further patients was limited by the complex needs of the patient group)
- Reviewed weekly patient community meeting minutes
- Inspected the clinic room
- Reviewed medication management (including prescription charts)

Summary of this inspection

- Conducted a detailed review of a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

The complex nature of the hospital's patient group meant that the majority of patients did not want to be interviewed as part of this inspection. When we observed direct patient care, patients appeared happy and sought support from staff when needed. We saw a card produced by a patient to thank a member of staff for their support and kindness.

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:

- Ligature points had been identified on both wards but no action had been taken to minimise this risk to patients.
- Cleaning records were not fully completed. Some ensuite bathrooms had been refurbished, but on Brightlingsea ward, we saw that the new toilets and sinks were stained. The ensuite bathrooms on Thorrington ward were similarly unclean with stains on the bathroom floors and around the toilet bases. These bathrooms also had a musty odour. We raised these issues immediately with the service manager.
- The paintwork in the bedroom corridors on Thorrington ward appeared tired and worn. Limited pictures were provided and the conservatory had window handles missing.
- Environmental risk assessments were undertaken and identified areas to address, but no timeframes were included for this work to be completed.
- Patients on Brightlingsea ward spent long periods in isolation for significant periods. This practice constituted long-term segregation.
- Nurses did not complete seclusion reviews and checks to safeguard patients in line with the Mental Health Act code of practice.
- Forty two percent staff were not up to date with mandatory training.
- The service had 28 staff vacancies.

However:

- There were no episodes of prone restraint used on patients.
- Risk assessments were comprehensive and reviewed regularly and if patients risk levels changed.
- Staff knew how to report incidents and the types of situation that required reporting.
- We saw evidence of staff debriefs following serious untoward incidents.
- Managers staffed shifts to the established levels of nurses (although these levels were at times achieved by using regular agency or bank staff).

Are services effective?

Good

We rated effective as **good** because:

Summary of this inspection

- Staff assessed patient's needs and care was delivered in line with individual care plans.
- Patient's physical healthcare examinations took place on admission and we found evidence of ongoing monitoring of physical health problems.
- Care plans were up to date, risk related, holistic and recovery focused.
- The assessment used to assess and record severity and outcomes for patients was the health of the nation outcome scales (HoNOS).
- The multidisciplinary team (MDT) included professionals from a wide variety of mental health disciplines. Multidisciplinary team meetings took place weekly.
- Senior staff addressed poor staff performance in a timely way.
- Mental Health Act 1983 and Mental Capacity Act 2005 documentation was good.
- Patients were not able to register with local GP services. A locum GP attended the service weekly to provide physical healthcare

However:

- Staff supervision records were not fully completed and showed that not all staff received monthly supervision.
- Nurses might find it difficult to access patient care and treatment records in an emergency as the information was stored in multiple files.

Are services caring?

Good

We rated caring as **good** because:

- Staff interacted with patients in a caring and respectful manner, remained engaged and interested in providing good quality patient care.
- Staff de-escalated situations well by talking calmly to patients and engaging in distraction techniques (including redirecting patients to other areas of the wards).
- Staff completed easy read care plans to ensure that patients could be involved.
- Patients gave feedback on the service via weekly service user groups.
- Patients had weekly access to independent advocacy.
- The provider supported and trained patients to become experts by experience so that they could work with staff to complete audits.

Are services responsive?

Good

We rated responsive as **good** because:

Summary of this inspection

- Bed management was effective. As an example: patients were able to return to their beds following periods of section 17 leave.
- The service had a range of rooms and equipment – including a dedicated occupational therapy suite with a sensory room.
- The kitchen provided a wide choice of meals for patients, and we saw evidence that this choice extended to catering for specific dietary requirements.
- Kitchen staff provided pictorial menus to support patients in choosing their meals.
- Programmes of weekly activities were on display in main ward areas and some patients' bedrooms.
- The provider displayed information in how to make a complaint in easy read formats throughout the service.

However:

- In the last six months, there were three delayed discharges. Managers told us that these delays were caused by issues with finding suitable community placements for departing patients.
- The service was not fully accessible for patients or visitors with physical disabilities. As an example,
- there were a number of steps in communal areas of the wards.
- Informal complaints were resolved at a local level but information was not collated to identify any lessons that could be learnt.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff knew the provider's values and believed they reflected the work they were involved with on the ward
- Staff participated in clinical audits and used information from these audits to improve the service and outcomes for patients.
- Managers had access to key performance indicators to gauge team performance and compare against other services.
- Managers held debrief sessions and staff meetings to share outcomes of incidents, complaints and patient feedback.

However:

- Annual appraisals were left uncompleted for many staff due to high turnover and new recruitment rates.
- Staff supervision did not take place on a regular basis.
- IT issues meant that staff could not rely on use of the electronic incident reporting system.

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.

- Thirty four percent of staff had received training in the Mental Health Act 1983 (MHA) and demonstrated a good understanding of the MHA and code of practice.
- We looked at four sets of detention documents. They were in good order, lawful and held in patient files.
- Doctors granted some patients section 17 leave. We saw that the forms included frequency and duration of the leave authorised for each individual patient, however, it was not evident if patients had a copy of the form.
- Consent to treatment forms had been completed and capacity requirements were adhered to. Copies of consent to treatment forms were attached to medication charts in all but one case. We reported this to the MHA administrator who provided us with a form and ensured it was attached to the medication charts on the day of the inspection. We saw that doctors discussed consent to treatment for medication with patients and recorded in case records.
- Patients had access to Independent mental health advocate (IMHA) 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.
- Staff used easy read section 132 rights were provided and read every two months to patients signed and documented in the patients case records.
- Support and legal advice on implementation of the MHA and code of practice were available onsite via the MHA administrator. It was also available from a centralised team in the provider's head office. Staff reported they would seek this support when required.
- The providers head office completed regular audits to ensure that the MHA was applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Thirty four percent of staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff could refer to a MCA policy which included DoLS if needed.
- Managers submitted three DoLS applications made between November 2014 and April 2015. Currently the service had one patient subject to DoLS and two patients where an application was pending. Senior staff followed up the applications with letter to the local authority to check on progress and evidenced this in case records.
- Staff assessed patient's capacity and recorded this in the case records in line with the MCA.
- Staff knew where to get advice from regarding MCA and DoLS.

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

- The wards we visited had blind spots where staff could not observe all areas of the ward. Staff managed this by carrying out regular observations regardless of individual assessments. We observed staff doing this throughout the inspection.
- Ligature audits had been completed for the service. Ligature points had been identified but no action had been taken to minimise the risk to patients. However, we saw staff managed these risks through the care they deliver. The services refurbishment programme will reduce/removed the current ligature risks.
- The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs. Equipment servicing had been carried out.
- Some of the ward areas were clean and had good furnishings. However, in the bedroom corridors on Thorrington ward the paintwork looked tired and worn, with limited pictures. The conservatory adjacent to the bedroom corridor had window handles missing. The manager told us that they had been removed by patients and had not been replaced due to the ligature risk they posed however; this meant that the windows could not be securely closed. The manger told us that this would be addressed in the refurbishment programme.
- Cleaning records were incomplete. Some ensuite bathrooms had been refurbished however we saw on Brightlingsea ward that the new toilets and sinks were stained. The ensuite bathrooms on Thorrington ward were not clean. We saw stains on the bathroom floors and around the base of the toilets. The bathrooms had a musty odour. We raised this immediately with the manager and were informed that the patients were supported to clean their bedrooms with staff and then the in-house cleaning service also cleans them. We were provided with the refurbishment program and noted that changes to the ensuites were to be completed by February 2016.
- Environmental risk assessments were undertaken. Staff identified areas that need to be addressed however, there were no set dates recorded for completion.
- Staff carried personal alarms that were checked daily to ensure that they were working effectively. Patients had no access to call bells in their bedrooms. Staff would manage this by using nursing observations during the day and at night.

Safe staffing

- The establishment figure for qualified nurses was eight, with seven currently in post.
- The established figures for support workers was 67, with 39 currently in post five recently and 23 being recruited to. The service had a on going recruitment plan.
- The service used agency and bank staff across the service. Managers preferred to use staff that was familiar to the ward. A sample of staff rotas and data provided during the inspection confirmed this. Between March and May 2015, 1095 shifts had been filled by bank or agency staff to cover sickness absence or vacancies. One shift had not been filled. A sample of staff rotas and data provided by the service showed that daily staffing numbers where met over a four-week period apart from one shift.

Good

Wards for people with learning disabilities or autism

- The hospital 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.
- Staff sickness rate was 2.9% in the last 12 months.This was below the national average.
- The hospital had a 20% turnover of permanent staff in the last 12 months. This impacted on the service, however managers reduced the impact by using regaulr agency staff and their on going recruitment process.
- Managers addressed staffing levels daily to take into account individual patient need and risk.
- A qualified nurse was present in communal areas of both wards at all times. The majority of patients were on enhanced observations. Patients were actively engaged in therapeutic activities with staff. The care treatment records inspected supported this.
- Escorted leave or ward activities were rarely cancelled due to staff shortages. We found that patients being supported to take walks in the grounds, to attend the occupational therapy suite and have bus ride.
- Medical cover was provided by two consultant psychiatrist sharing on call duties during the day and night. Staff contacted the consultants if there was an emergency on the ward.
- Fifty eight percent of staff had completed mandatory training. This meant that staff may not be equipped with the necessary skills to care for patients effectively.

Assessing and managing risk to patients and staff

- Between 01 November 2014 and 30 April 2015, 44 incidents of restraint were recorded. Of the 44 incidents, restraint was used on 13 different patients. There were no incidents of prone restraint and none resulting in rapid tranquilisation.
- Eighty percent of staff had been trained in breakaway techniques and 70% had been trained in full restraint techniques. The service had changed the type of restraint and was now using techniques, which were less restrictive than previous techniques, used. We saw that on both wards they had restraint mattresses. Staff used these if patients had to be taken to the floor during a restraint to minimise the risk of injury to the patient and staff.
- Staff used a number of distraction and de-escalation techniques throughout the inspection. Staff confirmed that de-escalation and other interventions were tried before using high levels of restraints.
- Individual risk assessments were comprehensive and reviewed weekly or if patients risk levels changed.
- Individual restrictions were in place for staff to minimise the risk to patients and for staff to support them.
- There was no information displayed on the wards about the rights of the informal patients.
- The service had a policy and procedure for observations. We saw that patients who were on observations had up to date records kept, including interventions that staff used to engage the patients in therapeutic activities.
- Doctors did not routinely prescribe rapid tranquilisation for patients.
- Brightlingsea ward was the bespoke service for four patients with complex and challenging needs who presented with risks to others. Patients nursed on this ward were nursed on two staff to one patient observations. Each patient had access to their own day area, kitchenette, bedroom, bathroom and secure garden. Records showed that detailed care plans and risk assessments were in place. Hourly observations were recorded and the multi-disciplinary team reviewed all four patients weekly. Support plans were in place to allow patients to integrate with peers during activities in the occupational therapy suite, hospital grounds and local community when risk assessed as safe to do so. However, the records did not highlight any plans for patients to be reintegrated into the main ward area. We raised this with members of the multi-disciplinary team who informed us that this practice was not deemed to be long-term segregation. However, this practice constituted long-term segregation as defined in the Mental Health Act 1983 code of practice. The provider had not carried out the three month external reviews as outlined in the code of practice.
- We observed that one patient was nursed in an area of the Brightlingsea ward on two staff to one patient nursing observation. The door to this room was locked. We were told that this was to prevent the patient trying to leave the area when he posed a risk to other patients or staff and encourage his involvement in therapeutic activity. Senior staff told us that they did not report or record this practice as seclusion as staff were present in

the area at all times. These meant nurses did not complete seclusion reviews and checks to safeguard patients in line with the Mental Health Act code of practice.

- Fifty five percent of staff had received training in safeguarding adults. Staff showed a good understanding of how to identify and report safeguarding concerns. We saw examples of recent safeguarding incidents on the ward and actions that had been taken as a result. Managers reported that there had been in improvement in the management of safeguarding incidents. They had regular meetings with the local authority safeguarding team to ensure that they follow the correct procedure.
- Medicines were stored securely and in accordance with the provider policy and manufacturers' guidelines. A community-based pharmacy provided services and completed medicines management audits. These audits were fully appropriately.
- Children were not allowed to visit on the main ward areas. Alternative visiting arrangements were provided in the occupational therapy suite.

Track record on safety

- The service had reported four serious incidents requiring investigation between 17 July 2014 and 14 September 2014. Managers investigated the incidents and we saw evidence of this.
- Monthly clinical governance and senior management meetings took place to discuss risk incidents and lessons learnt from them. This was shared at staff meetings.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents. The provider used a paper-based and electronic reporting system these. Local and senior managers could access this system. However, staff reported that there were issues using the electronic reporting system due to the poor internet access onsite. Senior managers were working to rectify the issues.
- Managers used the complaint process to be open and transparent when explaining to patients and families when things went wrong.
- Staff received feedback from investigations of incidents through daily debriefing meetings and monthly staff meetings. We saw minutes of these meetings which included safeguarding, supervision, training, policies and risk issues.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Staff assessed patient's needs and care was delivered in line with individual care plans.
- Patient's physical healthcare examinations took place on admission and we found evidence of ongoing monitoring of physical health problems.
- Staff completed body maps for patients who had a risk of harming themselves. If staff found an injury they recorded it in case records, an incident form was completed and investigated by senior staff.
- Care plans were holistic and included a full range of needs with specific interventions. Staff highlighted risks in individual assessments were linked to care plans and reviewed regularly. Patients had copies of their care plans in easy read version. Staff wrote clearly and concisely in care and treatment records notes.
- Information needed to deliver care and treatment effectively was stored within paper-based records. However, nurses might find it difficult to access patient care and treatment records in an emergency as the information was stored in multiple files.

Best practice in treatment and care

- De-escalation techniques were tried before considering other treatments for example rapid tranquilisation treatment for agitation or aggression in line with national guidance.
- Patients had behaviour support plans in place. They detailed interventions that staff should use to manage patient's behaviours in the least restrictive way. The plans were individualised, and focussed on proactive strategies.

Good

Wards for people with learning disabilities or autism

- A psychologist and an assistant psychologist provided patients with psychological therapies as recommended by the national institute for health and care excellence (NICE) three times a week in a group or individual sessions.
- Patients were not able to register with local GP services. A locum GP attended the service weekly to provide physical healthcare. If patients needed to access a GP during the week they attended a walk-in clinic. Managers told us that they had attempted to get a local GP service for the patients but were not successful. Managers had reported this issue to their clinical commissioning group and their local Member of Parliament, but had been unable to resolve this issue to date.
- Patients' care records showed that their nutrition and hydration needs were monitored and meet.
- The assessment used to assess and record severity and outcomes for patients was the health of the nation outcome scales (HoNOS).
- Clinical staff participated in clinical audits including as required medication (PRN) medication, infection control, medical devices and equipment and service users' money. Managers took the finding so the audits to measure performance and key themes in order to improve practice.

Skilled staff to deliver care

- The team consisted of nurses, occupational therapists, doctors, support workers and psychologists. The local authority provided social work support. Specialist assessments such as physiotherapy and speech and language therapy 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 had access to appropriate training, supervision and professional development. Records showed that staff had undertaken training relevant to their role in a variety of topics. For example, the occupational therapist had been enrolled on sensory integration training. Managers told us that all staff had access to the Danshell academy for training and development. The training plan supported the service to achieve objectives outlined in the quality strategy. The plan had training dates set throughout the year for a variety of training.
- Staff completed an induction prior to commencing work on the wards. The induction included training on whistleblowing, safeguarding, health & safety, information and data and MAYBO techniques.
- Staff supervision records were not fully completed and showed that not all staff received monthly supervision. The manager reported that attendance for clinical supervision was improving. The data showed that in the last three months staff attending supervision had improved from 6% staff in July to 29% in August. In September 28% staff had received supervision. Annual appraisals were left uncompleted for many staff due to high turnover and new recruitment rates.
- 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.

Multi-disciplinary and inter-agency team work

- There were weekly multidisciplinary team meetings.
- Shift to shift handovers took place within the wards where each patient was discussed individually and all relevant information was handed over as well as any outstanding actions that needed to be followed up. Staff documented handovers so that they could refer to the information if required.

Adherence to the MHA and the MHA Code of Practice

- Thirty four percent of staff had received training in the Mental Health Act 1983 (MHA) and demonstrated a good understanding of the MHA and code of practice.
- We looked at four sets of detention documents. They were filed correctly in patient files and were lawful.
- Doctors granted some patients section 17 leave. We saw that the forms included frequency and duration of the leave authorised for each individual patient however, it was not evident if patients had a copy of the form.
- Consent to treatment forms had been completed and capacity requirements were adhered to. Copies of consent to treatment forms were attached to medication charts in all but one case. We reported this to the MHA administrator who provided us with a form and ensured it was attached to the medication charts on the day of the inspection. We saw that doctors discussed consent to treatment for medication with patients and recorded in case records.

Good

Wards for people with learning disabilities or autism

- Patients had access to independent mental health advocate (IMHA) 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.
- Staff used easy read section 132 rights to explain rights to patients. These were read every two months to patients signed and documented in the patients case records.
- Support and legal advice on implementation of the MHA and code of practice were available onsite for via the MHA administrator. It was also available from a centralised team in the provider's head office. Staff reported they would seek this support when required. Policies had been updated in line with the new code of practice. The providers head office completed regular audits to ensure that the MHA was applied correctly.

Good practice in applying the MCA

- Thirty four percent of staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff could refer to a MCA and Dols policy if needed.
- Managers submitted three DoLS applications made between November 2014 and April 2015. Currently the service had one patient on DoLS and two patients where an application was pending. Senior staff followed up the applications with letter to the local authority t check on progress and evidenced this in case records.
- Staff assessed patient's capacity and recorded this in the case records.
- Staff knew where to get advice from regarding MCA and DoLS.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, dignity, respect and support

- Staff interacted with patients in a caring and respectful manner, remained engaged and interested in providing good quality patient care. We observed they de-escalated situations well by talking calmly to patients and redirecting them to other areas of the ward and engaging them in distraction.
- We saw a card produced by a patient thanking a member of staff for their support and kindness.
- Staff demonstrated a good understanding of individual patient needs in a range of settings and activities. Staff supported patients to attend to their activities of daily living, and therapeutic activities on and off the ward.

The involvement of people in the care they receive

- Prior to admission staff visit patients three times to begin to build therapeutic relationships with them and provide information to families and carers about the service.
- Staff supported patients to maintain regular contact with their families by arranging family holidays and home visits.
- Easy read is one way of making information more accessible to people with learning disabilitiesis a pictorial. This was in place to support patients to be patients involved in writing and reviewing their care plans. Staff recorded patients' likes and dislikes the patient centred care plans and gave patients copies.
- The hospital provided easy read multidisciplinary meeting forms for patients to complete by patients prior to them attending the meeting to give feedback to the team.
- Patients had access to advocacy. The service had commissioned its own independent advocacy service which visited the hospital once a week and would attend the hospital when more often if required.
- Families and carers were involved in the patient's care by attending ward rounds, care programme approach meetings and discharge planning. Care plans reflected patient's wishes for family and contact to and involvement in their care.
- Patients gave feedback to the service via service user groups facilitated by the occupational therapy. Patients recorded minutes on an easy read template. The minutes were available on notice boards throughout the service so that patients and staff could refer to them. A representative from the patient service user group attends regional and annual service user forum meetings.
- Staff gave Feedback forms to families and carers to complete and give return to the service.
- The hospital invited families and carers to attend family forums. The provider supported and trained patients to

Good

Wards for people with learning disabilities or autism

become experts by experience so that they could work with staff to complete audits. The service was developing training for patients so they could be involved with interviewing staff.

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

(for example, to feedback?)

Good

Access and discharge

- The average bed occupancy for the service over the last six months was 99%.
- Staff did not routinely move patients between wards during admission. However, managers reported that one patient was moved as his clinical needs were better supported within the bespoke service.
- Effective discharge planning was in place. For example when patients were ready for discharge placements near to families were considered as a priority. Staff would support patients to visit placements prior to discharge.
- In the last six months, there were three delayed discharges. Managers told us that issues with finding suitable community placements for departing patients caused these delays.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a range of rooms and equipment across the hospital. This included a dedicated occupational therapy suite including a sensory room. Thorrington ward had access to a secure outside space. On Brightlingsea ward each patient had their own garden.
- Patients had access to cordless phones that they could take to their bedrooms to make phone calls in private.
- The kitchen provided a wide choice of meals for patients, and we saw evidence that this choice extended to catering for specific dietary requirements. The food for patients with specific dietary needs was provided. Hot and cold drinks were available throughout the day as were snacks. Staff used pictorial menus to support patients to choose their meals.
- Patients were able to personalise their bedrooms with the choice of furniture, posters and bedding. Some patients' bedrooms lacked personal items. Staff told us that this was due to personal choice and individual patients' care plans.
- Programmes of weekly activities were on display in main ward areas and in some patients' bedrooms. Activities took place on the ward, in the occupational therapy suite and in the local community seven days a week.

Meeting the needs of all people who use the service

- The service was not fully accessible for patients or visitors with physical disabilities. As an example: there were a number of steps in communal areas of the wards. We observed that staff supported patients if required to gain access to communal areas. Patients with complex physical disabilities were not admitted to the service.
- Information on treatments, local services, patient rights, advocacy and how to complain was available in reception areas and in easy read version. If interpreters or people trained in sign language were required for meetings these were provided.

Listening to and learning from concerns and complaints

- One complaint had been made in last 12 months. Managers fully investigated the complaint and up held it. The complainant had received a letter informing them of the outcome. The majority of complaints were resolved at a local level. However, this information was not collated to identify any lessons learnt.
- The hospital provided easy read information on how to make a complaint and displayed throughout the hospital. Staff supported patients and families to make complaints if required.

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

Good

Vision and values

- Staff knew the provider's values and believed they reflected the work they were involved with on the ward.

Good

Wards for people with learning disabilities or autism

- The hospital published monthly newsletters for staff to update them on changes in the organisation.
- Staff knew who the senior managers were and reported that they were approachable and supportive.

Good governance

- Managers had access to key performance indicators to gauge the performance of the hospital and compare against other hospitals.
- Staff had access to yearly appraisals and clinical supervision. The data showed that appraisals and clinical supervision had been improving over the last three months.
- Managers identified potential risks within the hospital and fed this back at monthly board meetings for the Danshell group.
- Managers staffed shifts to the established levels of nurses (although these levels were at times achieved by using agency or bank staff).
- Staff participated in clinical audits. The findings of the audits were used to improve the service and outcomes for patients.
- IT issues meant that staff could not rely on use of the electronic incident reporting system. To mitigate this risk staff completed a paper based from which was later inputted in to the electronic system. Senior managers were addressing with the internet provider.
- Managers held daily de-brief sessions and staff meetings to share outcomes of incidents complaints and service user feedback. This process identified issues with staffing levels. Senior managers had increased staffing numbers at specific times of the day to support patient's needs.
- The hospital local risk register was linked to the provider's risk register. This was discussed by senior managers regularly to ensure that any identified risks were highlighted and acted upon effectively.

Leadership, morale and staff engagement

- Staff sickness and absence rates for the service was 2.9%. This is below the national average.
- Senior managers at the service were visible to staff and patients.
- There were no reported bullying and harassment cases.
- Staff knew how to use the hospitals whistleblowing procedure. They were confident to use the procedure or to raise concerns with senior managers if required.
- Staff told us that morale on the wards was good. They reported that there was a good skill mix and that all staff worked together as a team.
- There were opportunities for leadership development via a two-day course in leading and managing in the workplace.
- The hospital provided staff the opportunity to give feedback on services through monthly meetings and daily de-brief sessions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

•Ensure that cleaning records are fully maintained and all bathrooms are hygienic and free from stains and dirt.

•Ensure that the approach to and use of restraint and restrictive practices is regularly monitored and reviewed for compliance with national guidelines.

Action the provider SHOULD take to improve

- Ensure that all staff are up to date with mandatory training.
- Ensure that systems are in place for effective staff recruitment and retention.
- Ensure that insights gained from ligature and environmental audits are acted on.
- Ensure that staff receive regular supervision and appraisal.

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 15 HSCA (RA) Regulations 2014 Premises and equipment We 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 in breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant. Providers should: use appropriate cleaning methods and agents, operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment and monitor the level of cleanliness. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 15 (1) (a)

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 We found that the provider were not regularly monitoring and reviewing their approach to, and use of long-term segregation and seclusion. This was in breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes must be established and operated effectively to prevent abuse of service users.

This section is primarily information for the provider

Requirement notices

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 13 (2)

This section is primarily information for the provider

Enforcement actions

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.