Burton 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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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.

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

Summary of findings

Overall summary

We rated Burton Park as requires improvement because:

- The ward layout meant that there were numerous ligature risks and blind spots on all three wards. There were comprehensive risk assessments to mitigate this but not all recommended actions had been carried out on the wards for example they had not fitted curved mirrors on the corridors.
- When asked it took staff a considerable amount of time to look for ligature cutters on Warwick ward which were not in the place they were meant to be. In an emergency situation this could cause a potentially life threatening delay in staff getting to someone who had a ligature. A ligature is something such as rope or twine, tied around a part of the body, usually the neck in an attempt to self-harm or commit suicide.
- The fridge temperature in Cleves ward clinic room was high at ten degrees Celsius, and we could not find a record of fridge temperatures on Warwick ward. We were not assured that medication was kept at the required temperatures.
- Cleves ward was untidy and there was a smell of urine. We saw that a toilet on the ward was being used for storage.
- For one patient's record where rapid tranquilisation had been used there was no evidence that vital sign monitoring had been conducted.
- There were issues with the labelling, storage and prescribing of medication on all three wards. Inhalers and topical creams had not been labelled correctly meaning that it would be easy for staff to give the wrong medication to the wrong patient and it would have been easy to pass on infection. Not all medication that was prescribed for mental health was recorded on the T3 forms for patients detained under the Mental Health Act (1983).
- There were shortcomings with the environment particularly for bariatric patients who had restricted access to certain areas. Bariatric is the branch of medicine that deals with the causes, prevention, and treatment of obesity.
- Carers had complained that the provider's telephone system was not robust and it was difficult to get through to their relative.
- The hospital did not provide a specific multi-faith space in a quiet location where people of differing beliefs were able to spend some time in contemplation or prayer.

However we found the following areas of good practice:

- All care records were up to date, personalised, holistic with recovery orientated care plans and personal behavioural support plans.
- The team provided National Institute for Health and Care Excellence recommended psychological therapies, they also used the Independent Neurorehabilitation Providers Alliance guidance, to provide the most up to date evidence based information.
- Care records showed that patients received regular physical examinations and there was ongoing monitoring of physical health problems, including regular surgeries conducted at the hospital by the local GP and facilitating the support of patients to local hospitals when required.
- Staff used a wide range of recognised rating scales to assess and record the severity and outcomes of neurological conditions. These included; the functional independence measure and functional assessment measure, the St Andrew's Swansea neurobehavioural outcome scale, the supervision rating scale and the modified overt aggression scale.
- Staff received monthly supervision from their line manager and a reflective group for clinical supervision was offered monthly. Staff training records showed staff were up to date with their annual appraisal.
- We spoke with five patients during a focus group. All patients agreed that they were treated kindly by staff.
- We spoke with six carers of people staying at Burton Park, they all spoke highly of the care their relative received.
- Patients had an active involvement in their care planning and risk assessment.
- Patients had access to independent advocacy services.
- The provider had organised several family and carer events including a recent garden party. Carers told us that they were involved in their relative's care

programme approach reviews and received regular updates to any changes in their care plans where the patient had consented to their information being shared.

- Patients were actively involved in the recruitment of new staff, sitting on interview panels and taking candidates on tour of the wards.
- Managers ensured that staff were up to date with mandatory training.
- Managers chaired monthly clinical governance operational group meetings and monthly senior management team meetings.
- Shifts were covered by a sufficient number of staff with the correct grades and experience.
- The ward managers had sufficient authority to do their job and administration support.
- Staff we spoke with told us that staff morale was better as a result of changing to the new provider, and spoke of job satisfaction. We saw evidence of team working and mutual support.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Requires improvement 	

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at

Services for people with acquired brain injury.

Summary of this inspection

Background to Burton Park

Burton Park is an independent private hospital which has recently changed provider to The Priory Group. This location provides assessment, treatment and neurobehavioural rehabilitation for people with an acquired brain injury (including traumatic brain injury and stroke) and progressive neurological conditions who are over 18 years of age. The registered manager is Louise Smith.

Burton Park comprises:

Warwick Lodge - A 15 bedded unit. Within the 15 beds, there were 4 beds which are separated to provide transitional living. 11 beds provide care and treatment for those with a diagnosis of a progressive neurological condition, whose behaviour prevents them from accessing non-specialist services. The transitional living area, allows patients to test out their independent living skills in an environment that encourages confidence and independence in preparation for moving back into the community.

Cleves Lodge - A 26 bedded unit which provides care and treatment for people who have an acquired brain injury with behaviour that prevents placements within a less structured environment. The unit is split into two separate areas. 13 beds were provided for acute care and rehabilitation, 13 beds were provided for slow stream rehabilitation.

Dalby Unit - A 9 bedded female only unit for people with an acquired brain injury or progressive neurological condition. This was a rehabilitation ward for patients with greater independence to prepare themselves to move on, with less frequent staff support.

Burton Park has been registered with CQC since 8 December 2014.

There has been one inspection carried out at Burton Park on 21 and 22 October 2015 (inspection report published 27 April 2016). Burton Park is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

When previously inspected Burton Park was rated as requires improvement with requirement notices because:

The certificate of consent to treatment (T2) or certificate of second opinion (T3) forms, required under the Mental Health Act 1983, were not attached to the patients' medication charts. The resuscitation equipment, including the automated external defibrillator and suction machine, was not serviced on a regular basis.

This was a breach of regulation 12

Our inspection team

Team leader: Rachel Travis, Inspector, mental health hospitals, CQC

The team that inspected the service consisted of two inspectors, a CQC inspection manager, a CQC pharmacist and two specialist professional advisors including a nurse and occupational therapist who both had experience working with people who had acquired brain injuries.

Why we carried out this inspection

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

Summary of this inspection

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, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 18 patients who were using the service
- interviewed the registered manager and managers or acting managers for each of the wards
- spoke with 32 other staff members; including doctors, nurses, occupational therapist, a psychologist, social worker, rehabilitation assistants, speech therapists, and catering staff.
- we interviewed an independent advocate
- attended and observed two ward round meetings, one trans-disciplinary meeting and one breakfast community meeting
- led two focus groups for staff and one focus group for patients
- collected feedback from patients using comment cards
- looked at 18 care and treatment records of patients
- carried out a specific check of the medication management on two wards
- 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 five patients during a focus group; all patients agreed that they were treated kindly by staff. We spoke with six carers of people staying at Burton Park, all spoke highly of the care their relative received.
- One patient told us that there were limited activities at Burton Park especially at weekends.

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 ward layout meant that there were numerous ligature risks and blind spots on all three wards. There were comprehensive risk assessments to mitigate this but not all recommended actions had been carried out on the wards for example they had not fitted curved mirrors on the corridors. There were however sufficient numbers of staff carrying out observations of patients to mitigate the risk patients hiding in corners.
- When asked it took staff a considerable amount of time to look for ligature cutters on Warwick ward which were not in the place they were meant to be. In an emergency situation this could cause a potentially life threatening delay in staff getting to someone who had a ligature. A ligature is something such as rope or twine, tied around a part of the body, usually the neck in an attempt to self-harm or commit suicide.
- Inspectors found that the temperature of fridge in Cleves ward clinic room was high at ten degrees Celsius, and we could not find a record of fridge temperatures on Warwick ward.
- Cleves ward was untidy and there was a smell of urine, inspectors observed that a toilet on the ward was being used for storage.
- For one record where rapid tranquilisation had been used there was no evidence that physical health monitoring had been conducted.
- There were issues with the labelling, storage and prescribing of medication on all three wards. Inhalers and topical creams had not been labelled correctly meaning that it would be easy for staff to give the wrong medication to the wrong patient and it would have been easy to pass on infection. Not all medication that was prescribed for mental health was recorded on the T3 forms for patients detained under the Mental Health Act (1983).

However we saw the following examples of good practice:

- The wards complied with guidance on same sex accommodation. Dalby ward was used for female patients only.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs.
- Staff adhered to infection control principles including hand washing.
- The wards were safely staffed; a qualified nurse was present in communal areas of the ward at all times. There were enough

Summary of this inspection

staff to facilitate patients having regular 1:1 time with their named nurse. Escorted leave was rarely cancelled because of low staffing. There was adequate medical cover both during the day and at night.
- Staff were up to date with mandatory training with the average mandatory training rate being 92%. No elements of training fell below 75%.
- The provider used the Short -Term Assessment of Risk and Treatability risk assessment tool. This was completed on admission and regularly updated
- The provider had its own in-house trainer ensuring that all staff working at Burton Park received the correct training in managing violence and aggression.

Are services effective?

Good

We rated effective as good because:

- We looked at 18 patient care records. All records demonstrated a comprehensive assessment was completed on admission and regularly reviewed thereafter.
- Care records demonstrated that physical examination had been undertaken and that there was ongoing monitoring of physical health problems.
- All care records were up to date, personalised, holistic with recovery orientated care plans and personal behavioural support plans.
- The team provided National Institute for Health and Care Excellence recommended psychological therapies, they also used the Independent Neurorehabilitation Providers Alliance guidance, to provide the most up to date evidence based information.
- The team provided good access to physical healthcare including regular surgeries conducted at the hospital by the local GP and facilitating the support of patients at the general hospital when required.
- Staff ensured that patients' nutrition and hydration needs were assessed and met. Kitchen staff also provided meals tailored to patients' individual preferences.
- Staff used a wide range of recognised rating scales to assess and record the severity and outcomes of neurological conditions. These included: the functional independence measure and functional assessment measure, the St Andrews Swansea neurobehavioural outcome scale, the supervision rating scale and the modified overt aggression scale.
- The staff team comprised of a full range of mental health disciplines needed to deliver care.

Summary of this inspection

- Staff received regular supervision from their line manager monthly and a reflective group for clinical supervision was offered monthly. Staff received an annual appraisal with all staff being up to date with this.

However:

- All information needed to deliver care was stored in a variety of places in two electronic systems and paper format making it difficult for staff who did not know the wards to access it. Only permanent staff had access to information stored on the shared drive; this meant temporary staff were not able to access some information.

Are services caring?

Good

We rated caring as good because:

- We observed staff treating patients with dignity and respect; when staff were observing patients we saw them interacting with patients and providing appropriate levels of practical and emotional support to the situation.
- We spoke with five patients during a focus group; all patients agreed that they were treated kindly by staff.
- We spoke with six carers of people staying at Burton Park, all spoke highly of the care their relative received.
- Staff had a good understanding of the individual needs of the patient group.
- Patients had an active involvement in their care planning and risk assessment.
- Patients had access to independent advocacy services.
- The provider had organised several family and carer events including a recent garden party.
- Carers told us that they were involved in their relative's care programme approach reviews and received regular updates to any changes in their care plans where the patient had consented to their information being shared.
- Patients were actively involved in the recruitment of new staff.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There were shortcomings with the environment particularly for bariatric patients who had restricted access to certain areas. For example the width of door frames was too narrow to allow easy access for larger wheelchairs.
- Carers had complained that they telephone system was not robust and it was difficult to get through to their relative. The provider told us they had rectified this.

Summary of this inspection

- Staff provided a wide range of activities and therapies or patients throughout the week and a timetable of activities was displayed on each ward and in individual care plans, although two patients told us that these activities were not offered consistently.
- There was no specific multi-faith space in a quiet location where people of differing beliefs were able to spend some time in contemplation or prayer. However the provider told us that they were able to provide a private quite space for patients and visitors to use for such purposes and also utilised facilities in the community such as the local church.

However:

- The provider was responsive to referrals, usually being able to arrange assessment within a week of receipt of the referral.
- Patients had their own bedroom which they personalised if they wanted to.
- There were quiet areas on the ward where patients could meet relatives and relatives were permitted to meet with patients in their bedrooms.
- Adapted toilets were provided on each ward.
- The provider had a range of accessible information for patients including easy read information and information available in other languages. Staff told us that they could easily access interpreters or signers if necessary. Staff used pictures to communicate with patients who had difficulty understanding written communication.
- There was readily available information available for patients on their rights and how to complain.
- There was a choice of food to meet the dietary requirements of patients.

Are services well-led?

Good

We rated well led as good because:

- Managers ensured that the team objectives reflected organisational vision and values.
- Staff knew who the most senior managers in the organisation were, and the hospital director and lead nurse operated an open door policy towards staff, as well as making an effort to meet with staff on a monthly basis.
- The ward managers ensured that staff were up to date with mandatory training.
- Managers chaired clinical governance operational group meetings monthly and monthly senior management team meetings.
- Staff were supervised and appraised regularly.

Summary of this inspection

- Shifts were covered by a sufficient number of staff with the correct grades and experience.
- The ward managers had sufficient authority to do their job and good admin support.
- Staff had the ability to submit items to the organisational risk register.
- The management team rewarded good practice by team members offering staff of the month awards to staff whom they thought had made improvements in patient care.
- Staff told us that they felt well supported by the senior management team.
- There were no reported cases of bullying or harassment.
- Staff knew the whistleblowing process and were able to raise concerns without fear of victimisation.
- Staff we spoke with told us that staff morale was better as a result of changing to the new provider.They spoke about job satisfaction.
- We saw evidence of team working and mutual support.
- Staff were open and transparent and explained to patients if something went wrong.
- Management offered staff regular opportunity to give feedback on services and input into service development.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- The provider had a dedicated Mental Health Act administrator at the hospital and staff knew who this was. Administrative support and legal advice on implementation of the Mental Health Act and its code of practice was available from a central team.
- The service kept clear records of leave granted to patients, staff and carers were aware of the boundaries of leave granted including risk and contingency measures.
- Ninety four per cent of staff were up to date with Mental Health Act training. Staff we spoke with had a good understanding of the Mental Health Act, the code of practice and its guiding principles.
- There were issues with consent to treatment (T3) forms on each of the three wards. Although forms were attached to medication charts, in some cases the consent to treatment forms did not contain all medication that was stated on the prescription chart for mental health. We made the provider aware of this during the inspection and they rectified these errors immediately.
- There was evidence in patient records that people had their rights under the Mental Health Act explained to them on admission and routinely thereafter.
- Detention paperwork was filled in correctly, was up to date, and stored appropriately.
- Patients had access to an independent mental health advocate and staff were clear about how to access their support.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety four per cent of staff had training in the Mental Capacity Act.
- The provider had made 14 Deprivation of Liberty Safeguards (DoLS) applications within the six months prior to the inspection, the highest number of these was on Warwick ward.
- Staff we spoke with had a good understanding of the Mental Capacity Act 2005. Staff we spoke with understood and worked within the Mental Capacity Act definition of restraint.
- The provider had a clear policy on Mental Capacity Act, including DoLS, which staff were aware of and could refer to if necessary.
- For patients who lacked capacity to consent capacity assessments were conducted and recorded appropriately. This was done on a decision specific basis with regard to specific decisions, and people were given every possible assistance to make decisions for themselves before they were assumed to lack capacity.
- People were supported to make decisions and, when they lacked capacity, decisions were made in their best interest, recognising the importance of the individual's wishes, feelings, culture and history.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

Notes

Requires improvement

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Requires improvement

Safe and clean environment

- The ward layout meant that there were numerous ligature risks and blind spots on all three wards. There were comprehensive risk assessments to mitigate this but not all recommended actions had been carried out on the wards. For example, they had not fitted curved mirrors on the corridors. There were however sufficient numbers of staff carrying out observations of patients to mitigate the risk patients hiding in corners.
- The wards complied with guidance on same sex accommodation.
- Each ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that were checked regularly. However, when asked it took staff a considerable amount of time to look for ligature cutters on Warwick ward which were not in the place they were meant to be. In an emergency situation this could cause a potentially life threatening delay in staff getting to someone who had a ligature. A ligature is something such as rope or twine, tied around a part of the body, usually the neck in an attempt to self-harm or commit suicide.
- Inspectors found that the temperature of fridge in Cleves ward clinic room was high at ten degrees Celsius, and we could not find a record of fridge temperatures on Warwick ward.
- Two of the three ward areas were clean and well maintained however Cleves ward was untidy and there was a smell of urine, we observed that a toilet on the ward was being used for storage.
- Staff adhered to infection control principles, including hand washing.

Safe staffing

- Staffing levels at Burton Park were 12 whole time equivalent qualified nurses and 46 whole time equivalent rehabilitation assistants.
- The provider had a 39% turnover in the last twelve months. The vacancy rate was 11%. They had vacancies for four qualified nurses and ten rehabilitation assistants. Managers were holding staff interviews in the days following inspection.
- The provider had its own bank staff and had used these to fill 33 shifts across the hospital during the 12 months prior to the inspection. The provider had also filled 183 shifts with agency staff. The provider used one agency for qualified staff and one agency for unqualified staff. They provided bespoke training for agency staff and aimed to ensure that regular agency staff were familiar with the wards.
- The provider had a sickness rate of 3.4%
- The wards were safely staffed, a qualified nurse was present in communal areas of the ward at all times. There were enough staff to facilitate patients having regular 1:1 time with their named nurse. Escorted leave was rarely cancelled because there were too few staff.
- There was adequate medical cover both during the day and at night.
- Staff were up to date with mandatory training with the average mandatory training rate being 92%. No elements of training fell below 75%.

Requires improvement

Services for people with acquired brain injury

Assessing and managing risk to patients and staff

- The provider did not use seclusion at the hospital. Seclusion is defined as the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain people with severely disturbed behaviour which is likely to cause harm to others.
- The provider told us there were 389 episodes of restraint used in the last six months. The highest number of restraints was on Cleves ward which recorded 310 restraints used in the last six months. The provider told us the majority of restraints were at a very low level for example guiding patients by the arm. There were seven incidents (2%) of prone restraint on Cleves and one on Warwick during the six months before inspection. Prone restraint is a restraint technique where the patient is put on the floor chest down.
- The inspection team examined 18 patient records. All records contained comprehensive risks assessments and positive behavioural support plans. The provider used the short -term assessment of risk and treatability risk assessment tool. This was completed on admission and regularly updated.
- There were robust policies and procedures for the use of observations including minimising the risk from ligature points.
- We looked at two incidences where rapid tranquilisation had been used. For one record, there was no evidence that staff had carried out physical health monitoring.
- Staff we spoke with were trained in safeguarding. They knew how to make a safeguarding alert and reported safeguarding concerns to their line manager or directly to the provider's safeguarding lead.
- There were issues with the labelling, storage and prescribing of medication on all three wards. Inhalers and topical creams had not been labelled correctly meaning that it would be easy for staff to give the wrong medication to the wrong patient and it would have been easy to pass on infection. Not all medication that was prescribed for mental health was recorded on the T3 forms for patients detained under the Mental Health Act (1983).
- There were safe procedures for children that visit the hospital. A dedicated room was provided outside of the ward for such visits.

Track record on safety

- The CQC received 28 notifications in relation to Burton Park in the past twelve months up to 7 March 2017, most of these notifications related to allegations of abuse between patients.
- There had been three serious incidents requiring investigation, one unexpected death, one death in detention and one police incident.
- The provider had its own in-house trainer ensuring that all staff working at Burton Park received the correct training in managing violence and aggression.

Reporting incidents and learning from when things go wrong

- All staff we spoke with knew what to report and how to report incidents, escalating to their line manager or the safeguarding lead and if necessary recording on the electronic incident reporting system.
- Staff were open and transparent and explained to patients if and when things went wrong.
- Staff debrief was offered and staff told us they felt supported after serious incidents. Staff received feedback from investigation of incidents.
- Staff met to discuss the feedback from incidents in transdisciplinary meetings and during individual and group supervision. The transdisciplinary model is one where specialist professionals inform the formulation and care plan of patients but the interventions may be carried out by all members of the transdisciplinary team.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- The inspection team reviewed 18 patient care records. All records demonstrated comprehensive assessment completed on admission and regularly reviewed thereafter.
- Care records demonstrated that physical examination had been undertaken and that there was ongoing monitoring of physical health problems.

Requires improvement

Services for people with acquired brain injury

- All care records were up to date, personalised, holistic with recovery orientated care plans and personal behavioural support plans.
- All information needed to deliver care was stored securely although was stored in a variety of places in two electronic systems and paper format making it difficult for staff who did not know the wards to access it. Only permanent staff had access to information stored on the shared drive, meaning that agency staff were not able to access some information.

Best practice in treatment and care

- The team provided National Institute for Health and Care Excellence recommended psychological therapies, they also used the Independent Neurorehabilitation Providers Alliance guidance, to provide the most up to date evidence based information.
- The team provided good access to physical healthcare including regular surgeries conducted at the hospital by the local GP and facilitating the support of patients at the general hospital when required.
- Staff ensured that patient's nutrition and hydration needs were assessed and met. Kitchen staff also provided meals tailored to patients' individual preferences.
- Staff used a wide range of recognised rating scales to assess and record the severity and outcomes of neurological conditions. These included the functional independence measure and functional assessment measure, the St Andrews Swansea neurobehavioural outcome scale, the supervision rating scale, and the modified overt aggression scale.
- Clinical staff participated in neurobehavioural audits and regularly audited the therapy programme.
- The provider recently conducted a patient survey to gain patient opinion of their care but results of this were unclear, staff were not sure that patients had a clear understanding of the questions. The survey was being repeated using simplified questions and pictures to gain patient opinion.

Skilled staff to deliver care

- The staff team comprised a full range of mental health disciplines including nurses, consultant psychiatrists, social workers, occupational therapists, speech and language therapists, dietician, rehabilitation assistants, psychologists, neuropsychologists, a vocational training lead, safeguarding lead, training and education lead for staff, and physical healthcare lead. Staff provided input to the ward using a transdisciplinary team model. The transdisciplinary model is one where specialist professionals inform the formulation and care plan of patients but the interventions may be carried out by all members of the transdisciplinary team.
- All staff were suitably experience and qualified for their role. All staff received an appropriate induction and rehabilitation assistants used their probation period to work towards their care certificate. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe compassionate care.
- We reviewed staff recruitment files for ten staff. All staff had completed disclosure barring service checks and these checks were repeated on a three yearly basis. Membership and revalidation to professional bodies had been complied with where relevant.
- Staff received regular supervision from their line manager monthly and a reflective group for clinical supervision was offered monthly. Staff received an annual appraisal with all staff being up to date with this.
- Managers addressed poor staff performance promptly and managers told us that the majority of poor performance issues had been addressed during the probationary period.

Multi-disciplinary and inter-agency team work

- The provider held regular transdisciplinary meetings, one of which we observed during inspection. Staff spoke positively about patients during the meeting which was focused on problem solving aspects of a patient's care package which required review.
- There was evidence of effective handovers within the teams on each of the three wards. Handovers were recorded in communication records.
- There was evidence in care records of effective working relationships with teams outside of the hospital for example when patients moved on from the service to other care providers.

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support

Requires improvement

Services for people with acquired brain injury

- We observed staff treating patients with dignity and respect, when staff were observing patients we saw them to be interacting with patients and providing appropriate levels of practical and emotional support to the situation.
- We spoke with five patients during a focus group all patients agreed that they were treated kindly by staff.
- We spoke with six carers of people staying at Burton Park, all spoke highly of the care their relative received.
- Staff had a good understanding of the individual needs of the diverse patient group.

The involvement of people in the care they receive

- Patients were orientated to the wards on admission to the hospital and informed of the service they could expect to receive.
- Patients had an active involvement in their care planning and risk assessment. This was corroborated by patients. However, the care planning documentation did not always clearly demonstrate whether patients had received a copy of their care plan.
- Patients had access to independent advocacy services.
- The provider had organised several family and carer events including a recent garden party. Patients and carers had been involved in the planning of this event.
- Carers told us that they were involved in their relative's care programme approach reviews and received regular updates to any changes in their care plans, where the patient had consented to their information being shared.
- Patients had recently been undertaking audits of the environment with staff.
- The provider was in the process of designing a patient survey to enable patients to give feedback on their care.
- Patients were actively involved in the recruitment process and were able to suggest changes to service provision at regular community meetings, through 1:1 sessions, and through the independent advocate. The provider also had a patient representative at their clinical governance operational meetings.

Are services for people with acquired brain injury responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

- Burton Park reported their average bed occupancy by ward for the period 1 September 2016 to 28 February 2017 as follows: Warwick Unit 73%, Dalby Unit 67%, and Cleves Unit 61%.
- Patients were not routinely moved between wards during admission unless justified on clinical grounds in the interest of the patient.
- The provider was responsive to referrals usually being able to arrange assessment within a week of receipt of the referral.
- In the six months prior to inspection there had been two delayed discharges from the hospital. One on Dalby ward due to the external care package taking time to be finalised, and one on Warwick Unit due to lack of bed availability in the commissioning area.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedroom which they personalised if they wanted to.
- There were quiet areas on the ward where patients could meet their carers and relatives.
- Patients were able to make phone calls in private although carers had complained that the telephone system was not robust and it was difficult to get through to their relative. The provider acknowledged this complaint and was in the process of rectifying this.
- The provider had substantial outdoor areas and patients were supported to regularly access designated outside space to each ward. We saw this in use during the inspection.
- A range of hot drinks and snacks were available to patients on their request and where able patients were able to make their own snacks.
- Patients had locked cupboards in which they could store valuable possessions and patients were individually risk assessed for their suitability to have a key to their bedroom door.

Requires improvement

Services for people with acquired brain injury

- Staff provided a wide range of activities and therapies for patients throughout the week and a timetable of activities was displayed on each ward and in individual care plans, although two patients told us that these activities were not offered consistently.

Meeting the needs of all people who use the service

- There was a lift patients in wheelchairs could use to access the parts of the ward that were on the second floor. However, there were shortcomings with the environment particularly for bariatric patients who had restricted access to certain areas. For example the width of door frames was too narrow to allow easy access for larger wheelchairs.
- Adapted toilets were provided on each ward.
- The provider had a range of accessible information for patients including easy read information and information available in other languages. Staff told us that they could easily access interpreters or signers if necessary. Staff used pictures to communicate with patients who had difficulty understanding written communication.
- There was readily available information available for patients on their rights and how to complain.
- There was a choice of food to meet the dietary requirements of patients.
- There was no specific multi-faith space in a quiet location where people of differing beliefs were able to spend some time in contemplation or prayer. However the provider told us that they would provide a quite area for staff and patients to use if requested and they actively utilise faith services in the local community.

Listening to and learning from concerns and complaints

- There was a total of four complaints made to Burton Park in the period between 1 February 2016 and 28 February 2017. Of these one complaint was made twice. One complaint was upheld and the other two partially upheld and changes were made as a result of all complaints by the provider. One complaint was about the telephone system not being effective and has now been rectified. Another complaint was upheld after a member of staff removed a personal alert system from a patient due to alleged misuse, this staff member was removed. None of the complaints were referred to the ombudsman.
- Burton Park received seven compliments during the 12 months from 1 February 2016 to 28 February 2017.
- Patients we spoke with knew how to complain and received feedback on their complaint. We saw evidence of "You said, we did " minutes which detailed changes made by the provider.
- Staff told us that they received feedback from investigations of complaints and acted on the findings.

Are services for people with acquired brain injury well-led?

Good

Vision and values

- The provider had recently changed and as such the vision and values of the Priory were new to staff at the hospital. Managers had recently held an away day for staff to help embed the new values.
- Managers ensured that the team objectives reflected organisational vision and values.
- Staff knew who the most senior managers in the organisation were. The hospital director and lead nurse operated an open door policy towards staff, as well as making an effort to meet with staff on a monthly basis.

Good governance

- Managers ensured that staff were up to date with mandatory training.
- Managers chaired monthly clinical governance operational group meetings and monthly senior management team meetings.
- Staff were supervised and appraised regularly.
- Shifts were covered by a sufficient number of staff with the correct grades and experience.
- Managers ensured that staff maximised their shift-time on direct care activities as opposed to admin tasks.
- Staff participated in clinical audit and ensured that incidents were appropriately reported.
- The provider uses key performance indicators and outcome measures to gauge the performance of the team. The measures were in accessible format and used by the staff team to develop active plans when issues were identified.
- The ward managers had sufficient authority to do their job and good administration support.

Requires improvement

Services for people with acquired brain injury

- Staff had the ability to submit items to the organisational risk register.

Leadership, morale and staff engagement

- The management celebrated good practice by staff offering staff of the month awards
- Staff told us that they felt well supported by the senior management team.
- There were no reported cases of bullying or harassment.
- Staff knew the whistleblowing process and were able to raise concerns without fear of victimisation.
- Staff we spoke with told us that staff morale was better as a result of changing to the new provider. They spoke of job satisfaction. We saw evidence of effective team working and mutual support.
- Staff were open and transparent and explained to patients if something went wrong.
- Management offered staff regular opportunity to give feedback on services and input into service development.

Commitment to quality improvement and innovation

- The provider was committed to the use of improvement methodologies and had recently published an article on the clinical effectiveness of the service determined through data collected from the use of outcome measures.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the proper and safe management of medicines.
- The provider must ensure the environment is safe, clean and well maintained. The provider must ensure that ligature cutters are stored in such a way that that staff know where they are and can access them quickly in the event of emergency.
- The provider must ensure that Mental Health Act T3 forms are accurate with regard to the medicine prescribed and administered to the patient.
- The provider must ensure that monitoring of physical health patients is completed in adherence to guidance from the National Institute of Health and Care Excellence.
- The provider must ensure that the environment is such that all patients can access all areas of the ward.

Action the provider SHOULD take to improve

- The provider should ensure that the telephone system supports patients to make and receive calls.
- The provider should consider a revision of its record keeping system to ensure that records are easily accessible and contemporaneous.
- The provider should provide a consistent level of activities throughout the week.

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 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9. The environment on Warwick ward was such that patients in bariatric wheelchairs could not access all areas of the ward. This was a breach of Regulation 9.

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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12. Mental Health Act T3 forms were not always accurate with regard to the medicine prescribed and administered to the patient on the prescription chart. Medicine refrigerator temperatures were outside of the normal range in one of the fridges. Physical health monitoring of patients was not always completed following rapid tranquilisation medication. Some ward areas were dirty and posed an infection control risk. Ligature cutters were not easily available for staff in an emergency. This was a breach of Regulation 12.