Burston House

Quality Report

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

Ratings

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

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

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

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

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 Burston House as good because:

- Patients were fully risk assessed on admission to the hospital. Staff developed care plans and positive behaviour support plans for patients, all in easy read format, and included risk reduction. We found these to be thorough, informative and personalised to the patient. Physical health care, nutrition and hydration needs were met. Staff supported patients to live healthier lives.
- The hospital delivered a range of psychological therapies suitable for the patient group. The interventions were those recommended by and delivered in line with, guidance from the National Institute for Health and Care Excellence. Staff knew the patients well and supported patients to understand and manage their care, treatment, and conditions. The patients we spoke with said they felt happy, relaxed and calm at the hospital, and that staff cared for them well.
- Family and carers told us that staff were friendly, helpful and informative and communicated well. Carers and family members felt they could contact the hospital at any time. The hospital provided support through the onsite social worker. On admission they received an admission booklet with details of services offered this included information on the Mental Health Act.
- Staff at the hospital felt respected and supported by managers. We observed a positive culture and close working teams during our visit. Staff felt that they really made a difference and the culture at the hospital was person centred care which gave real job satisfaction. Staff, patients and carers had access to up to date information about the work of the hospital and services they used. Patients could meet with members of the organisations leadership and give feedback on service they received.

However:

- The hospital did not ensure medication audits were actioned. We found out of date stock medication and first aid box supplies. There were inconsistencies in the recording of opening dates of medication across the hospital. There was a lack of oversight by managers to ensure those concerns identified by audit were acted upon.

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 	

Summary of findings

Contents

Good

Burston House

Services we looked at
Wards for people with learning disabilities or autism;

Summary of this inspection

Background to Burston House

The Priory Group provide low secure inpatient learning disability services at Burston House Hospital in Norfolk. The location is registered by the Care Quality Commission

for the provision of:

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

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury.

There is a registered manager in post at the hospital who is also the controlled drugs accountable officer. The hospital provides services to patients with learning disabilities within low secure facilities. It consists of one 15 bedded unit and two eight bedded units. Patients at Burston House were male and all were detained under the Mental Health Act. Kestrel ward provides assessment and treatment. Patients may have a forensic history and, in addition to having a learning disability, patients may have behaviour that is challenging.

Eagle ward is an eight-bedded pre-rehabilitation unit. This service is designed for those patients to gain independent living skills prior to placement in specialist rehabilitation services.

Rectory ward is an eight-bedded low secure rehabilitation service. Patients on this ward will have completed their assessment and treatment programmes.

The hospital has onsite vocational and leisure facilities including a gym, gardening and woodwork. There were 26 patients receiving treatment at Burston House. Burston House was registered with the Care Quality Commission in December 2010. The last inspection was carried out on19 20 December 2016. The Care Quality Commission rated this service as good at this inspection.

At this inspection we found that this service had fully met and addressed actions from our previous inspection in December 2016.

Action the provider SHOULD take to improve

- The provider should review the average length of stay for each patient at this hospital.
- The provider should ensure staff have regular supervision, all supervisions are recorded and dates are logged.

Our inspection team

The team that inspected the service comprised three CQC inspectors and one specialist nurse advisor who had experience of working with people with learning difficulties and autism.

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.

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 14 patients who were using the service
- spoke with three carers of patients
- spoke with the registered manager and two managers for the three wards and the site services manager
- spoke with 11 other staff members; including doctors, nurses, occupational therapist, psychologist and social worker
- attended and observed one hand-over meeting and one morning site meeting
- looked at nine care and treatment records of patients
- carried out a specific check of the medication management on three 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 14 patients and three carers of patients.

The patients we spoke with said they felt happy, relaxed and calm. Patients told us they had talk time with staff, they were given effective coping strategies and that staff cared for them well. However, one patient raised they did not feel safe and we raised this with the hospital. Managers assured us this would be dealt with appropriately.

Carers we spoke with were complimentary about the hospital they told us staff were very kind, helpful and informative. Staff communicated well and were responsive to returning calls, and were involved in the care and treatment of patients. We observed staff being very caring toward their patients and knew them and their needs well.

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:

- We found six different types of stock medications out of date varying from May 2018 to January 2019. This had been raised by the pharmacy who attended and audited weekly, and no action had been taken. We found the first aid boxes had out of date stock in them, and had been signed and checked by staff regularly. There were inconsistencies in the recording of opening dates of medication across the site.
- One patient with an identified clinical need and at risk of choking had not received an up to date speech and language therapy assessment.
- There were insufficient hand gel dispensers working in key areas of the hospital during our visit to adhere to infection control principles.
- There were occasions when staffing on the wards was not sufficient to provide patients with their planned community activities.
- Patient did not have call bells available in their bedrooms.

However:

- Staff carried out environmental risk assessments across the hospital this included the grounds.
- Care and treatment records showed all patients had a risk assessment on admission and these were regularly updated, this included following an incident where we found these to be thorough and informative. All patients had positive behaviour support plans in place, all in easy read format and included risk reduction for the patient. These were reviewed regularly.
- A qualified nurse was present on the wards at all times. Staffing allowed for one to one time with named nurses and the patients notes reflected this. All Information needed to deliver patient care was available to staff, this included agency staff. Wards had access to a quick read folder on the ward. This meant that all staff visiting from another ward, agency or directly employed were aware of the needs and risks of the patients in their care.
- The wards at the hospital participated in the providers restrictive intervention reduction programme. The trainer delivered physical intervention alongside positive behaviour support training. We observed during our inspection staff using de-escalation techniques to positive effect.

Summary of this inspection

- The registered manager and social worker were the safeguarding leads for the hospital. The hospital held six weekly meetings with the local multi-agency safeguarding hub. Staff showed a good understanding of the safeguarding process.

Are services effective?

Good

We rated effective as good because:

- Patients' physical health needs were met. On admission to the hospital there was a brief physical health assessment by the responsible clinician. This was followed up within seven days with the GP. There was a weekly GP clinic held on site which offered full physical health screen. Patients' recovery outcomes were clearly identified and documented, this included patient's comments. Patients had access to physical healthcare this included dentist and opticians.
- Staff developed care plans and positive behaviour support plans that met the needs of the patient. Care plans were up to date, detailed and personalised.
- The hospital delivered a range of psychological therapies suitable for the patient group. The interventions were those recommended by and delivered in line with guidance from the National Institute for Health and Care Excellence. This included offence specific treatments.
- Staff worked well as part of a multidisciplinary team and held regular and effective multidisciplinary meetings with full patient involvement and feedback. Managers and staff described an effective working relationship with other relevant teams within the organisation, community teams, and care coordinators.
- Staff assessed and met patients' needs for nutrition and hydration. Staff supported patients to live healthier lives. We saw staff engaging with patients in an activity of keeping a food diary monitoring the food they were eating, and to encourage healthy choices.
- The hospital had access to full range of specialists to meet the needs of the patients on the ward. The hospital was still actively recruiting for a full time speech and language therapist. Staff had access to regular team meetings on the wards. Staff received regular supervision and appraisals. These included progress planning annually. Learning was available to staff through the e learning system and this was comprehensive.

However:

- Staff at the hospital were not able to tell us who their Mental Health Act administrator was.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Staff knew the patients well. We observed staff engaged in various activities. Staff supported patients to understand and manage their care, treatment, and conditions. The patients we spoke with said they felt happy, relaxed and calm. Patients told us they had talk time with staff, they were given effective coping strategies and that staff cared for them well.
- Staff fully involved patients in care planning, this was well documented. Patients had a positive behaviour support plan and had a copy of their care plan in their rooms and were aware of their goals and objectives. Those patients with physical health care needs had a separate care plan which was detailed and comprehensive.
- Patients could give feedback on the service they received through patient surveys, patient council meetings and weekly ward meetings. There were site specific men's service meetings held which were attended by patient representatives from the hospital.
- Family and carers told us that staff were brilliant and amazing, very friendly, helpful and very informative. Staff communicated well and were very responsive to returning calls. Carers and family members felt they could call anytime.
- The hospital provided support for carers and family members through the onsite social worker. On admission they received an admission booklet details of services offered this included information on the Mental Health Act. Carers said that if they needed anything they could contact the social worker and they would be supported.

Are services responsive?

Good

We rated responsive as good because:

- Patients had their own bedrooms and could personalise them. We saw evidence of this throughout the inspection. There were personal belongings in their rooms, such as family photographs, their own bedding and curtains. The bedrooms were individual to each patient.
- There was a full range of rooms available for patients and staff at the hospital, including a clinic room, lounge and separate dining areas. There were kitchens on each ward. The Rectory kitchen was used by patients who purchased and cooked their own food as part of the rehabilitation pathway. There was a fully equipped life skills, education and vocational opportunities service on site.

Summary of this inspection

- Staff ensured that drinks were available to patients throughout the day, and all patients were provided with a snack locker with their own key. Staff encouraged patients to make healthy choices.
- The hospital had two activity coordinators who reviewed and produced an activity timetable on a weekly basis. There was a wide range of activities available during the week. This included trips off site and a daily walk challenge in the outside activity area. The hospital ran patient events each month.
- Staff knew the communication needs of their patients. All wards had patient information provided in an accessible format. Patients knew how to complain and had the opportunity to raise complaints at monthly patient ward meetings. Staff and patients were given feedback.

Are services well-led?

Good

We rated well-led as good because:

- Managers had a good understanding of the services they managed and were clearly visible on the wards and were approachable for patients and staff. Staff interviewed spoke highly of the managers and the support they received.
- Staff could describe to us the fundamental core values and commitment to providing person centred care and a progressive rehabilitate environment for patients.
- Staff at the hospital felt respected and supported by managers. We observed a positive culture and close working teams during our visit. Staff felt that they really made a difference and the culture at the hospital was person centred care which gave real job satisfaction.
- The hospital recognised staff success within the organisation. Staff photographs were displayed in the reception area for employee of the month, which was an award given at local level, and employee of the year which was part of the providers star awards.
- Staff, patients and carers had access to up to date information about the work of the hospital and services they used. For example, through meetings carers are invited to attend and care plans posted to carers homes in a timely manner. There was a continuous open link for engagement with the wards and the onsite social worker. Patients could meet with members of the organisations leadership.

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.

- Ninety three percent of staff were trained in the Mental Health Act at the time of inspection. Staff had a good understanding of the Mental Health Act and the guiding principles.
- The hospital had a Mental Health Act administrator who carried out audits on Mental Health Act papers. The hospital ensured section papers and Ministry of Justice warrants were seen and correct prior to admission. This was carried out by a central team for the hospital, a member of staff had received extra training with medical records in Mental Health Act and Deprivation of Liberty Safeguards and the role was to ensure these were correct on admission and relevant paperwork sent. However, staff at the hospital were not able to tell us who their Mental Health Act administrator was. Staff were aware of where they could seek advice via a help line on the intranet, and where to access local Mental Health Act policies and procedures and the Code of Practice.
- Patients had access to the advocacy service available at the hospital. Patients had access to easy read information for this service. Advocacy attended the hospital regularly and supported patients in relevant meetings.
- Patients' rights were explained on admission. The named nurse would then review this and rights were explained on a regular basis thereafter. Those patients who did not understand their rights received regular explanations supported by easy read leaflets. Staff recorded this on their electronic record. Records were checked and a report generated by the Mental Health Act administrator on a regular basis.
- Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this was granted. Patients were leaving the hospital for this during our visit. A Ministry of Justice leave audit was completed monthly for restricted patients. This was to ensure leave taken was authorised and within the areas permitted.
- Care plans referred to Section 117 aftercare services and this was discussed and clearly documented at the multidisciplinary meetings for patients.
- The Mental Health Act administrator completed individual monthly audits of consent to treatment, section renewals and managers hearings and mental health tribunals. This generated a monthly report which evidenced the Mental Health Act was applied correctly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty-nine percent of staff had completed training and were up to date with the Mental Capacity Act at the time of inspection. Staff evidenced a good understanding of the principles of the Mental Capacity Act during this inspection.
- Staff training for Deprivation of Liberty Safeguards was at 93%.
- Staff assessed patients on admission and medication charts included capacity to consent to treatment. This was recorded in care and treatment records. Capacity assessments were decision specific, and supported patients to make decisions where possible. The hospital provided easy read leaflets about capacity decisions.
- Staff were observed supporting patients with best interest decisions. For example, a best interest decision was made for a patient to be administered an influenza vaccination. When patients lacked capacity, staff made decisions in their best interest, and recognised the persons wishes feelings and history.
- The hospital had arrangements in place to monitor adherence to the Mental Capacity Act. This was audited by the central team and action taken from lessons learnt.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

- Staff carried out environmental risk assessments across the hospital this included the grounds.
- The Hospital was not a purpose-built building and wards had blind spots where staff could not observe areas at all times. One corridor on the ground floor of Kestral ward did not have a convex mirror in place. The ward manager had mitigated this risk by placing a staff member in this area at all times. All other ward areas had convex mirrors in place so staff could see down the corridors.
- Each ward had a ligature risk assessment in place which identified and mitigated the risk.
- All patients at the hospital were male which meant the hospital complied with guidance on eliminating mixed-sex accommodation.
- All staff and visitors to the hospital carried personal alarms. Staff had access to radios and security checks were carried out daily. Patient bedrooms did not have call bells. Staff managed this by using observations during the day and night.
- All wards were cleaned regularly and had good furnishings. The hospital site improvement plan developed in August 2018 identified some areas of concern. Work had due dates for completion which had been met. There were some actions due for completion by the end of March 2019. Two actions were due for completion by October 2019 these were regarding the improvement of fixtures across sites as a part of a review being conducted by the provider.
- Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly.
- There were insufficient hand gel dispensers working in key areas of the hospital during our visit to adhere to infection control principles. This was raised at the time of inspection and was resolved during our visit. There were hand washing signs throughout the hospital and staff adhered to hand washing principles.
- There was a seclusion room at the hospital situated on Kestrel ward. The seclusion room allowed for clear observation and had two-way communication. There was a clock for patients, and staff could control the temperature from outside the room. The seclusion room had a separate toilet and shower located in the seclusion area. Staff told us the shower had a poorly designed floor and when used water would leak from the door. However, there were plans in place to address this.
- The hospital had one main clinic room with accessible resuscitation equipment and emergency drugs that staff regularly checked. All equipment was clearly labelled and calibrated. There was a fridge for medication and temperatures were checked. There was provision for a GP to carry out physical health monitoring. This was equipped with weighing scales, blood pressure and heart rate monitor. The three wards had a small dispensary for medication these areas were very small and were cluttered. The equipment in these areas was clean and maintained with visible cleaned stickers.

Safe staffing

Good

Wards for people with learning disabilities or autism

- The hospital informed us that the wards had high vacancy rates. At the time of inspection, the vacancy rate for nursing staff across the hospital was 59% and for health care workers 11%. Managers had an ongoing recruitment process for the hospital which included open recruitment days. Managers told us that staffing of the night time shifts had improved and had been filled with permanent posts.
- Managers calculated shifts using a workforce plan in line with best practise and NHS safer staffing principles. Senior nurses met on a weekly basis to look at resources across the hospital. Shifts were filled by bank and agency staff for the week ahead and safe staffing levels were agreed twice per day for the day and night shifts.
- Data provided showed over a 12-month period 863 shifts were filled by bank or agency staff. These were highest on Kestrel ward. When staffing levels fell below the required numbers, staff who worked outside the staff numbers were available to support the wards to deliver care treatment. Roles such as the activity co-ordinations and staff working in the vocational centre of the hospital.
- Managers used long term bank and agency staff to cover vacancies and periods of staff sickness. These staff knew the patients and were familiar with the wards. Managers would book shifts in advance which ensured continuity of care for patients. All bank and agency staff received an induction to the ward when working at the hospital.
- A registered nurse was present on the wards at all times. Staffing allowed for one to one time with named nurses the patients notes reflected this. However, some patients told us there were times when this was not the case.
- Records reviewed showed patients had planned section 17 leave and we observed this during our inspection. Patients attended activities with the activity coordinators of the hospital. However, patients told us that on Rectory and Eagle wards the unplanned leave and activities were at times cancelled or rescheduled due to unexpected staff shortages.
- We saw evidence of planned leave for patients who live out of area. Visits had been facilitated by the hospital.
- Eighty three percent of staff were trained to carry out physical interventions. We observed during our inspection staff using de-escalation techniques to positive effect.
- There was adequate medical cover day and night at the hospital. There was a doctor on call if required and staff would contact 111 and 999 if any situation required this.
- Staff were up to date with mandatory training. Hospital training records showed overall staff in the service had undertaken 96% of training required.

Assessing and managing risk to patients and staff

- We reviewed nine care and treatment records, which showed all patients had a risk assessment on admission and these were regularly updated by staff, this included following an incident where we found detail to be thorough and informative.
- Staff used recognised risk assessment tools at the hospital. However, one patient with an identified clinical need and at risk of choking had not received an up to date speech and language therapy assessment.
- All patients had positive behaviour support plans in place. This was in easy read format and included risk reduction for the patient. Plans were reviewed regularly at the treatment formulation meetings held at the hospital.
- Staff followed policies and procedures for the use of observations and searching of patients, there was clear and concise evidence recorded in the progress notes of the care and treatment records we reviewed.
- The hospital was a non-smoking site and staff adhered to the smoke free policy of the hospital.
- There were 51 incidents of seclusion between 01 April 2018 and 30 September 2018. Forty-eight of these were on Kestrel ward.
- We reviewed 13 seclusion records. These were in paper form and then added to the electronic system. Patients were reviewed in a timely manner. However, four out of the 13 records reviewed care plans and seclusion checklists had not been filed in accordance with hospital procedures. However, we saw evidence of all seclusion paperwork on the electronic system.
- There had been one incident of long term segregation in the last 12 months prior to inspection. The facilities of long term segregation met the expectations of the code of practice. This had been regularly reviewed. We saw that the patient's bedroom was homely and personalised and had full access to bathroom facilities, open air and activities. On the day of inspection, the patient was assessed to consider if a step up to medium secure was appropriate.

- There were 148 incidents of restraint between 01 April 2018 and 30 September 2018. Involving 19 patients within this period. Four of these incidents resulted in prone restraint. These were where the patient initiated the prone position during the incident. We reviewed three records of patient restraint in detail and the incident reporting paperwork was thorough and detailed. Some patients needed low level restraint only. Staff used de-escalation techniques as soon as possible. None of these restraints resulted in rapid tranquilisation.
- The wards at the hospital participated in the providers restrictive intervention reduction programme. The restraint training coordinator delivered physical intervention alongside positive behaviour support training. This training included the use of pods (bean bags specially designed for use during restraint) to reduce the use of prone. The data showed there had been a reduction in prone restraint since the last inspection.
- Seclusion figures had increased, a high number of incidents related to two patients. One patient would prefer seclusion for a short period where he felt safe and was able to de-escalate his behaviour before returning to the ward. Staff recognised that the use of seclusion was the safest way to prevent further risk of aggression. We saw evidence on inspection of staff managing seclusion well and supported patients to de-escalate their behaviours.

Safeguarding

- Ninety-eight percent of eligible staff had received both safeguarding children and adults training. There had been 22 safeguarding referrals since 1 November 2018. Twenty-one related to Kestrel ward and one for Eagle ward. Themes included patient on patient abuse. Staff showed a good understanding of the safeguarding process.
- The registered manager and social worker were the safeguarding leads for the hospital. The hospital held six weekly meetings with the local multi-agency safeguarding hub.
- Staff followed safety procedures when children visited. All children visit requests went through the hospital social worker in advance, and ensured that the visit was in the best interest of the child. There was a suitable area provided for children's visits away from patient areas.

Staff access to essential information

- All staff had access to the electronic system for patient records. Staff had no difficulty accessing or entering information including bank and agency staff.
- All information needed to deliver patient care was available to staff, this included agency staff. Wards had access to a quick read folder on the ward containing each patients picture, their diagnosis, physical health needs, dietary requirements, risks, likes, dislikes, communication needs, and their positive behaviour support plan in easy read format. This meant that all staff visiting from another ward, agency or directly employed were aware of the needs and risks of the patients in their care.

Medicines management

- Staff followed good practice in most areas of medicines management in line with national guidance. However, this was not the case for the disposal of medication. We found six different types of stock medications out of date varying from May 2018 up to January 2019. This had been raised by the pharmacy who attended and audited weekly and no action had been taken. We found the first aid boxes had out of date stock in them and had been signed and checked by staff regularly. There were inconsistencies in the recording of opening dates of medication across the site. We raised these concerns at the time of inspection with the ward manager, and these were dealt with immediately. All out of date medication was disposed of as per laid down procedures, and a process was put in place ensuring clinical oversight to prevent recurrence in the future.

Track record on safety

- Between 1 April 2018 and 30 September 2018, the ward reported three serious incidents. The nature of these incidents included allegation of sexual abuse on one occasion and property damage on two occasions. There were no serious incidents recorded since 1 October 2018.

Reporting incidents and learning from when things go wrong

- Staff knew how to report incidents. Staff explained how these were reported through the electronic system and through to senior managers on the hospital dashboard.

Good

Wards for people with learning disabilities or autism

- Since 1 October 2018 there were 291 incidents recorded on the electronic recording system. The main themes were patient on staff assault and patient on patient low level aggression. We looked at a sample of seven incidents. All incident reports were fully completed and signed off. These included immediate actions, physical interventions and management plans.
- Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong. We were provided with examples of this during our inspection through the social worker at the hospital.
- Staff received feedback from incidents this included investigation outcomes. This was achieved through debriefs, emails and monthly lesson learnt posters displayed on the wards for staff.
- Staff were debriefed following incidents and supported by managers at the hospital.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed nine care and treatment records staff completed comprehensive mental health assessments following admission, these were completed in a timely manner.
- Patients' physical health needs were met. Physical health was part of pre-admission planning for each patient. On admission to the hospital there was a brief physical health assessment by the responsible clinician. This was followed up within seven days with the GP. There was a weekly GP clinic held on site which offered full physical health screen, including blood screens, and annual physical health checks. Patients recovery outcomes were clearly identified and documented, this included patient's comments.
- Staff developed care plans and positive behaviour support plans that met the needs of the patient during assessment. Care plans were up to date detailed and personalised to the patient. These included trigger risks, alerts, current successes and risk reduction plans.

Best practice in treatment and care

- The hospital delivered a range of psychological therapies suitable for the patient group. The interventions were those recommended by and delivered in line with guidance from the National Institute for Health and Care Excellence. This included offence specific treatments in addition to dialectical behaviour therapy, mindfulness, equip groups and drug and alcohol awareness.
- The occupational therapist provided wards with activities such as happy group, relaxation gardening and model making. There was a real work opportunity group looking at volunteer opportunities, this was in the planning stages. Sessions delivered were measurable by model of human occupation (a client centred model that is grounded in occupational therapy).
- Patients had access to physical healthcare this included dentist and opticians. Patients could attend these services in the community and for those who could not access the community these services visited patients on site.
- Staff assessed and met patients' needs for nutrition and hydration. However, we found one patient who needed a review by a speech and language therapist as the last assessment review was over one year. This was raised during inspection and the manager agreed to arrange an assessment for this patient.
- Staff supported patients to live healthier lives. Smoking cessation was available at the hospital for patients. However, there was little demand as the no smoking policy was well embedded at the hospital. We saw staff engaging with patients in activity of keeping a food diary monitoring the food they were eating, and to encourage healthy choices. This was part of an event called the biggest loser. Staff were also taking part in this event.
- Staff used recognised rating scales to assess the severity of outcomes. For example, Health of the Nation Outcome Scales.
- Staff told us they had participated in in audits such as infection prevention control and medication audits. The organisation had an audits dashboard with target dates for completion.

Skilled staff to deliver care

- The hospital had access to a full range of specialists to meet the needs of the patients. This included consultants, qualified nurses, healthcare workers,

occupational therapist, pshycologist, art therapist, social worker, activity coordinators and vocational centre instructors. The hospital had a speech and language therapist employed for one day per month. However, the hospital was still actively recruiting for a full time post to meet the needs of patients.

- The staff were experienced and qualified, and had the right skills and knowledge to meet the need of the patient group.
- The hospital provided new staff with an induction over a two-week period. This included workbooks to be completed during their induction period and reviewed by managers. health care workers completed the care certificate standard during their probationary period. There was an induction provided for bank and agency staff, and those staff were offered further training such as prevention and management of violence and aggression and positive behaviour support.
- Managers provided annual appraisals and monthly supervision for staff. Staff confirmed this happened on a regular basis and throughout the month if required. We saw evidence of this recorded in staff files. This was an improvement since the last inspection in December 2016. The consultants at the hospital told us they received support and had regular continuous professional development, case supervision and delivered presentations to each other on different topics.
- Staff had access to regular team meetings on the wards. This included a daily handover meeting. There was a daily site meeting for the hospital which included all partner hospitals in the organisation. All relevant concerns and information discussed would be fed back to the ward staff by managers.
- The percentage of staff that had had an appraisal in the last 12 months prior to inspection was at 100%.
- The percentage of staff who had received regular supervision was Eagle ward 100%, Rectory ward 88%, and Kestrel ward at 85%. We saw four examples of group supervision records these included the following examples of topics discussed, patient issues and case studies, observation levels, seclusion, patient engagement, security and night checks.
- Staff told us appraisals included progress planning annually, and a lot of learning was available to staff through the e learning system and this was comprehensive. One member of staff had recently been supported by the hospital and had become a qualified physical education instructor for the hospital. A student nurse who had been on placement at the hospital had taken up a full-time post.
- The hospital provided staff with training in learning disabilities and autism as part of their role.
- Managers informed us that poor performance was dealt with promptly and effectively. We reviewed six staff files and saw evidence of documented meetings with staff to support this.

Multi-disciplinary and inter-agency team work

- Staff worked well as part of a multidisciplinary team and held regular and effective multidisciplinary meetings. The hospital held these over a two-day period per ward giving the opportunity for full patient involvement and feedback.
- Staff shared patient information during the daily handover meeting on each ward. We attended morning handover on Kestrel ward where we observed this.
- The ward managers attended the daily site meeting. This ensured information was shared across all sites. This meant when staff were deployed between the hospitals they were fully aware of risks, concerns and presentations of all patients on the wards.
- Managers and staff described an effective working relationship with other teams within the organisation, community teams, and care coordinators.
- The staff had an effective relationship with teams outside of the organisation. For example, the local authority attended the hospital every six weeks for meetings. The local GP attended on a weekly basis.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Ninety three percent of staff were trained in the mental Health Act. Staff had a good understanding of the Mental Health Act and the guiding principles.
- The hospital had a Mental Health Act administrator who carried out audits on Mental Health Act papers. The hospital ensured section papers and Ministry of Justice warrants were checked and correct prior to admission. This was carried out by a central team for the hospital, a member of staff had received extra training for medical records in Mental Health Act and Deprivation of Liberty safeguards and the role was to ensure these were correct on admission, and relevant paperwork sent. However, staff at the hospital were not able to tell us

who their Mental Health Act administrator was. Staff were aware of where they could seek advice via a help line on the intranet, and where to access local Mental Health Act policies and procedures and the Code of Practice.

- Patients had access to the advocacy service at the hospital. Patients had access to easy read information for this. Advocacy attended the hospital regularly and supported patients in relevant meetings.
- Patients' rights were explained on admission. The named nurse would review this and rights were explained on a regular basis thereafter. Those patients who did not understand their rights received regular explanations supported by easy read leaflets. Staff recorded this on their electronic record. Records were checked and a report generated by the Mental Health Act administrator on a regular basis.
- Staff ensured that patients could take section 17 leave (permission for patients to leave hospital) when this was granted. Patients were leaving the hospital for this during our visit. A Ministry of Justice leave audit was completed monthly for restricted patients. This was to ensure leave taken was authorised and within the areas permitted.
- Care plans referred to Section 117 aftercare services and this was discussed and clearly documented at the multidisciplinary meetings for patients.
- The Mental Health Act administrator completed individual monthly audits of consent to treatment, section renewals, managers hearings and mental health tribunals. This generated a monthly report which evidenced the Mental Health Act was applied correctly

Good practice in applying the Mental Capacity Act

- Eighty-nine percent of staff had completed training and were up to date with the Mental Capacity Act. Staff evidenced a good understanding of the principles of the Mental Capacity Act during this inspection.
- Staff training for Deprivation of Liberty Safeguards was at 93%.
- Staff assessed patients on admission and medication charts included capacity to consent to treatment. This was recorded in care and treatment records. Capacity assessments were decision specific, and supported patients to make decisions where possible. The hospital provided easy read leaflets about capacity decisions.
- Staff were observed supporting patients with best interest decisions. For example, a best interest decision was made for a patient to be administered an influenza vaccination. When patients lacked capacity, staff made decisions in their best interest, and recognised the persons wishes feelings and history.
- The hospital had arrangements in place to monitor adherence to the Mental Capacity Act. This was audited by a central team and action taken from lessons learnt.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff knew the patients well and we observed staff engaged in various activities. Staff were consistently kind, compassionate and caring, speaking to patients in a friendly manner with appropriate humour. Staff introduced us to patients when we arrived on the wards and patients were advised why we were at the hospital.
- Staff supported patients to understand and manage their care, treatment and conditions. For example, some patients self-administered their medication with easy read material. Ensuring independence was promoted to progress the patient to the community. One patient had been taught to manage and monitor blood sugar levels using easy read material and was now fully independent in managing this condition.
- We spoke with 14 patients. The patients we spoke with said they felt happy, relaxed and calm at the hospital, they had talk time with staff. Patients said they were given effective coping mechanisms such as use of a sensory room, stress balls, and the staff cared for them well. However, two patients told us they did not feel there was enough activity and that activities were cancelled, and there was no use of the gymnasium and this impacted on patient's health. One patient told us they did not feel safe and explained to us the reasons for this. This was raised with the hospital manager who assured us they would support this patient, discuss the concerns and take any appropriate action.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Involvement in care

Good

Wards for people with learning disabilities or autism

- Staff used the admission process to inform and orient patients to the ward and to the service. Patients received an information booklet and staff showed patients around the ward and introduced them to ward representatives for support.
- Staff fully involved patients in care planning this was well documented. Patients had a positive behaviour support plan and a copy of their care plan in their rooms, and were aware of their goals and objectives. Those patients with physical health care needs had a separate care plan which was detailed and comprehensive. Patients were involved in their multidisciplinary meeting and had the opportunity to give feedback.
- Staff communicated well with patients and were aware of patient's individual needs. For example, patients with communication difficulties were supported with aids to help them.
- The hospital had involved patients in the recruitment of staff. For example, advocacy and social worker interviews.
- Patients could give feedback on the service they received through patient surveys, patient council meetings and weekly ward meetings. There were site specific men's service meetings held which were attended by patient representatives from the hospital.
- Patients knew how to access advocacy and said they visited the hospital regularly and staff would help them make referrals. There were easy read leaflets available for this.
- Family and carers told us that staff were brilliant and amazing, friendly, helpful and very informative. Staff communicated well and were very responsive to returning calls. Carers and family members felt they could call anytime. Two carers we spoke with said they were regularly involved in all decision making and invited to attend regular meetings. One carer said they were always invited to meetings but were unable to attend due to where they live. However, they spoke with staff over the telephone but not often face to face. Care plans were sent in a folder via post two days after a care programme approach meeting. One carer stated, "the care plans are spot on". However, one carer told us that there can be a shortage of staff at times and had found that Section 17 leave had been cancelled as a result of this.
- The hospital provided support for carers and family members through the onsite social worker. On admission they received an admission booklet details of services offered this included information on the Mental Health Act. Carers said that if they needed anything they could contact the social worker and they would be supported. One carer stated the social worker was brilliant and one carer said the contact was regular, brilliant and quoted "ten out of ten".

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

(for example, to feedback?)

Good

Access and discharge

- Burston House has 31 beds, there were 26 patients at the time of our visit. Bed occupancy rates were 83% for Kestrel, 93% for Eagle and 99% for Rectory ward. Patients on Kestrel could progress to Eagle for pre-rehabilitation and the Rectory for rehabilitation as part of the hospital pathway for treatment progression.
- The average length of stay was three years and five months, this reflected the complexity of the patients using the service. However, the length of stay had decreased since our last inspection. The hospital was working to address this through Commissioning for Quality Care and Innovation scheme. This was monitored monthly. For example, one patient had completed treatment, the hospital requested assessment for suitability of a low secure placement nearer the patient's home.
- The ward manager told us he was very proud of some of the recent discharges from the hospital of long term patients, and some family members still contacted the hospital and talked to staff.
- The hospital accepted patients from all parts of the country. Patents were discharged to suitable placements near home if possible. Discharge planning meetings took place where aftercare services were regularly considered and documented.
- There was always a bed available for those patients returning from leave. Patient movement between wards was part of the progression pathway and would not

move wards during an admission episode. Patients who transferred to Burston House as part of progression would be assessed and if suitable would be admitted straight into a rehabilitation ward at the hospital.
- Staff could give examples of visiting a new placement with patients or patients visiting Burston House for placement. Visits to their new environment was part of the transition process.
- The hospital had one delayed discharge in the last 12 months this was due to funding with commissioners.
- Staff planned for patients discharges. There was detailed documented evidence in meeting minutes and patient care and treatment records. There were good links and communication with care coordinators.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms and could personalise their bedrooms. We saw evidence of this throughout the inspection. There were personal belongings in their rooms, such as family photographs, their own bedding and curtains. The bedrooms were individual to each patient. For example, one patient was interested in old movies and superheroes. Staff had gone above and beyond to locate life-size cut-outs and memorabilia for this patient's room. Staff explained how they offered choice to their patients to make their rooms individualised and supported them to do so.
- There was a full range of rooms available for patients and staff at the hospital, including a clinic room, lounge and separate dining areas. There were kitchens on each ward. The Rectory kitchen was used by patients who purchased their own food for the ward and did their own cooking. This was a part of the rehabilitation pathway. There was a fully equipped life skills, education and vocational opportunities service on site. This gave patients the opportunity to go off the ward. This facility provided a kitchen, classrooms, health and beauty room, art therapy room, IT classroom, and wood workshop. This aimed to encourage patients to engage in activities to maintain and develop their educational, vocational and independent living skills.
- The wards had quiet and low stimulus areas for patients. We observed these being used by patients with staff during our visit to positive effect. The hospital provided dedicated room for visitors off the wards.
- Patients had access to phones on the wards and could make calls in private. Each ward had a mobile phone for patient use and for family members to call the ward. Patients on restrictions were well managed and had access to this facility. The Rectory ward patients had use of their own personal mobile phones. Patients signed a contract of agreement for this.
- Each ward area had their own garden area with seating, some of which was made by patients in the wood workshop. There was a large courtyard and garden which was accessed by all patients and used for activities such as football and daily walks. This area had gym equipment available for patients to use.
- Patients had a range of food available at mealtimes. The hospital had conducted patient surveys in May 2018 and November 2018, the feedback from these surveys had not yet been received. However, during our visit we held a patient forum where patients told us they felt the meal choices could be more varied.
- Staff ensured that drinks were available to patients throughout the day, and all patients were provided with a snack locker with their own key, these could be accessed at any time. Staff encouraged patients to make healthy choices.

Patients' engagement with the wider community

- The hospital had two activity coordinators who reviewed and produced an activity timetable on a weekly basis. We spoke with other members of the educational skills team. There was a wide range of activities available during the week. This included trips off site and a daily walk challenge in the outside activity area for all patients and staff. The hospital ran patient events each month, at the time of inspection these were Dechox February (where patients and staff were refraining from eating chocolate) and the biggest loser (looking at diet and healthy food planning) both activities were part of healthy eating being encouraged at the hospital. Activities at the weekend were more limited due to staff resources at times. The hospital had recently trained a health care worker as a gym instructor for patients. However, was not facilitating activities as part of the patient timetable at the time of inspection.

Meeting the needs of all people who use the service

- The hospital was not fully accessible to disabled patients. However, there were patient's bedrooms available on the ground floor on all wards where patients with some physical restrictions could be accommodated.

Good

Wards for people with learning disabilities or autism

- Staff knew the communication needs of their patients and ensured these were met. All wards had patient information provided in an accessible format. For example, easy read leaflets and staff had access to leaflets in other languages if required.
- Managers ensured staff could access outside services for sign language and interpreters if there was a patient need.
- Patients had food choice to meet their dietary requirement and meet any religious or spiritual needs.
- The hospital offered a multi faith room to patients and had a visiting chaplain on a weekly basis. staff told us they could access appropriate spiritual support for any patients that required it.

Listening to and learning from concerns and complaints

- The hospital had systems for the recording and management of complaints. When staff received a complaint, Managers wrote to the complainant to acknowledge receipt and explained the process. We reviewed three complaints and all were responded to within the required timescale.
- Between 1 April 2018 and 30 September 2018, four complaints were made to Burston House. Three of these related to Kestrel Ward and one to Rectory ward. Examples of complaints included, bullying by a member of staff, patient weight gain, restriction of internet access and concern regarding appropriateness of placement.
- There were three further complaints since the first of October 2018. One complaint for each ward. Two complaints related to communication issues and one to a patient on patient assault.
- Patients knew how to complain and had the opportunity to raise complaints at monthly patient ward meetings.
- The registered manager told us that staff and patients were given feedback regarding complaints. We saw evidence in minutes of patient, staff and clinical governance meetings that complaints were discussed and included themes, lessons learnt and outcomes. There was evidence that changes had been made as a result of feedback. For example, patients wanted more exercise. The hospital put in place a daily walk as part on their monthly events held, and had recently trained a healthcare worker in gym instructing.

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

Good

Leadership

- Managers had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Managers were clearly visible on the wards and were approachable for patients and staff. Staff interviewed spoke highly of the managers and the support they received from them on a daily basis. Staff informed us that the teams on the wards were like an extended family and worked well together.
- Managers said there had been some leadership development opportunities given to them within their role.

Vision and strategy

- Staff could describe to us the fundamental core values and commitment to providing person centred care, and a progressive rehabilitate environment for patients. We observed staff applying these in their work on a daily basis.

Culture

- Staff at the hospital felt respected and supported by managers. We observed a positive culture and close working teams during our visit. Staff felt that they really made a difference and the culture at the hospital was person centred care which gave real job satisfaction. Six members of staff told us they loved working at the hospital they were like a family.
- The hospital had undertaken a culture of care barometer with staff which is a service tool to help organisations gauge the culture of care they provide. The positive responses from staff were respect from co-workers and managers. Staff said they felt confident to ask for help when required. Staff also raised in least positive responses resources and values. The hospital had been responsive and put an action plan in place following the findings of this survey.

- Staff felt able to raise concerns without fear of retribution. Most staff were aware of the whistleblowing process and stated they would not hesitate to follow this if there was a need.
- Managers dealt with performance management concerns when they needed to. We saw evidence of this in the staff files we viewed.
- Teams across the hospital worked well together and this was observed consistently throughout our inspection. Managers dealt with staff appropriately when needed.
- Staff appraisals were annual and were due at the time of inspection staff told us they felt they included conversations regarding their career development. Staff told us there is a lot of training available to staff through the organisation. For example, one member of staff recently attended training around epilepsy to further develop their knowledge. Which was supported and provided by the hospital.
- The staff sickness and absence rate for the hospital had improved since the last inspection. Between October 2017 and September 2018, the sickness rate was at 4.1% compared to 5.4% on our last visit.
- The hospital recognised staff success within the organisation we saw staff photographs displayed in the reception area for employee of the month, which was an award given at local level, and employee of the year which was part of the providers star awards. The ward manager of Kestrel ward had been put forward for manager of the year award nationally within the organisation.

Governance

- The hospital and the organisation had a clear governance framework in place. Managers had oversight of staff training, appraisals and supervision. Supervision for staff had improved since the last inspection. Patients average length of stay was reviewed regularly and managers had a good understanding and oversight in this area.
- The managers had ensured that skills and numbers of staff on the wards met the assessed needs for patients. Staff understood the arrangements for working with other teams, both within the organisation and externally to meet the needs of the patients.
- The hospital had a framework for ward, team and governance level meetings. Staff followed these agendas and had documented actions and outcomes. Management information was reviewed and shared with staff by managers.
- Managers held monthly lessons-learned meetings where incidents were reviewed. A lessons-learned poster produced monthly. This was published and displayed on the ward. We saw examples for December 2018, January 2019 and February 2019. These included lessons learnt at a local (site) level and lessons from national partner organisations. The updates also included intervention statistics for the month compared to the previous month for physical interventions, seclusions and incidents. There was also a section highlighting good practice. For example, December 2018 update highlighted compliance with the Health and safety audit.
- Managers told us that clinical audits were undertaken at the hospital. We saw evidence that quality assurance, including audits, were discussed at the operational senior management team meetings for November 2018 and January 2019.

Management of risk, issues and performance

- Ward managers were aware of the local risk register and said they could contribute to this. This was accessible on the shared drive on the electronic system.
- The hospital had plans for emergencies. For example, serious outbreak of infection or pandemic, and severe weather conditions. The plan covered areas such as emergency food supplies, staff and patient safety.

Information management

- The hospital had an information management policy. Patients' confidential personal information was stored securely. Staff had the technology required to carry out their role.
- The hospital had effective systems in place to enable staff to report to external bodies. This was demonstrated when safeguarding logs were reviewed.

Engagement

- Staff, patients and carers had access to up to date information about the work of the hospital and services they used. For example, through meetings carers were

invited to attend, and care plans posted to carers homes in a timely manner. There was a continuous open link for engagement with the wards and the onsite social worker.

- The organisation undertook a carers survey in January 2018 and received six responses for Burston House hospital. Every three months the organisation collected patient safety data. All patients were encouraged to complete questionnaires. However, the hospital is awaiting this data back from Healthcare data to enable managers to use this feedback to make improvements.
- Patients could meet with the members of the organisations leadership. The representatives from the patient council attended the service governance meetings. This information was taken forward to regional meetings to the board. The board then cascaded this back down to ward level meetings.
- Senior leadership of the organisation conducted a weekly quality walk round of all sites and staff had the opportunity to raise any issues. Staff told us the chief executive officer of the organisation had also attended the hospital and listened to staff. For example, the condition of the carpets was raised. Following this visit carpets were removed and new wooden flooring put into place.

Learning, continuous improvement and innovation

- Staff were given support to consider opportunities for improvements and innovation. For example, the organisation asked ward managers and staff to consider how they could reconfigure and improve Kestrel ward environment, and asked that team ideas were fed back to the senior management to consider. The staff told us they felt the organisation was were keen to invest in improving patients living conditions.
- The hospital participated in cycle six of the Quality Network for Forensic Mental Health in March 2018 and was noted to have fully met 82% of low secure standards. The site achieved 100% of criteria in six standard areas including, Relational Security, Safeguarding, Admission, Medication, Leave and Discharge and Governance. Areas noted in need of improvement over the next year included, environment and facilities, activity provision and planning, continuity of advocacy services and food. The hospital was currently involved in annual peer reviews.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that medicine audits are adhered to and acted upon to prevent out of date medication.
- The provider must ensure medication opening dates are consistently recorded.

Action the provider SHOULD take to improve

- The provider should ensure first aid supply checks include expiry dates and these are recorded.
- The provider should ensure call bells are available to patients in their bedrooms.
- The provider should ensure that patients who require an annual assessment by an allied professional have their needs met.
- The provider should ensure there are sufficient staff so that patients activities are undertaken as planned.
- The provider should ensure infection control principles are adhered to and hand gel provided in the key areas of the hospital.
- Staff should be aware of Mental Health Act administrator support and role.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure the proper and safe use and disposal of medicines.