Partnerships in Care Limited

Burton Park

Inspection report

Warwick Road
Melton Mowbray
LE13 0RD
Tel: 01664484194
www.priorygroup.com

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this service went down. We rated it as inadequate because:

- Staff had failed to follow the Mental Health Act Code of Practice when caring for a patient in long term segregation. Staff had not recognised this as segregation despite the patient not being able to freely mix with other patients on the ward for five months.
- Managers failed to ensure patients who received medicines covertly had a care plan in place detailing how staff complete this safely. Patients who received medicines through a percutaneous endoscopic gastrostomy (PEG) also had no detailed care plan in place instructing staff how to ensure medicines given by this route follows best practice guidance.
- Staff had not consistently followed the Mental Capacity Act when assessing capacity to make specific decisions relating to medicines and the use of an electronic cigarette (vaporiser).
- Staff could not locate all agency staff induction paperwork. We were not assured that this consistently took place. There was a lack of detail within agency staff profiles, particularly around mandatory training, what levels they had completed and when.
- Due to the provider using a number of different care agencies to cover shifts, we were not assured that they had all received reducing restrictive interventions training in line with the providers own policy, and in line with national guidance.
- The service had not had any regular psychology staff in post for at least 12 months despite some individual care plans listing psychological interventions and / or goals.
- The provider used a high volume of agency staff to cover shifts. The majority of these were healthcare assistants. Agency healthcare assistants did not have access to patients' electronic notes. They had to rely upon other staff inputting information on their behalf.
- Staff did not always follow individual care plans relating to oral health and mouthcare, and cleaning and rotation of percutaneous endoscopic gastrostomy (PEG) sites.
- Patients had not consistently received feedback following on from suggestions made or concerns raised during community meetings.

However:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Managers ensured staff had regular supervision and an annual appraisal of their work.
- Staff actively involved patients, families and carers in care decisions when it was possible to do so, and appropriate consent had been sought.
- Staff teams held regular team meetings which were recorded.
- We saw some kind and caring interactions between staff and patients during inspection.
- We spoke with some highly motivated and compassionate staff members.
- We saw the wards had a variety of easy read documents.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Burton Park

Priory Burton Park is a 50-bedded, neuro rehabilitation service, who predominantly provide care and treatment for patients with acquired or traumatic brain injuries, including stroke. The service also offers continuing care for people who have progressive neurological conditions, such as Huntington's disease and early onset dementia. The hospital aims to deliver person centred care with specialist targeted neurological rehabilitation, with focus upon the physical, functional, cognitive, emotional, and social needs of people.

The hospital has three separate units:

Warwick is a 15-bed ward for people with an acquired brain injury with associated complex neurological physical needs, who may also need support in communicating feelings or distress. The unit also accommodates people who have neurological conditions, requiring ongoing care and support. The unit accommodates males and females.

Cleves unit has 26 beds, with the focus being upon rehabilitation for those who need comprehensive rehabilitation and support. The ward accommodates people with an acquired brain injury with complex neurological needs, who may also need support in communicating feelings or distress. The unit accommodates males and females.

Dalby was previously a 9-bed unit for people who had made significant progress and were at the pre-discharge stage of their recovery journey, with emphasis being upon community access. However, this was closed at the time of inspection. Senior management were having ongoing discussions about re-opening and the purpose of this unit.

The service had a relatively new hospital director in post, who was going through the process of becoming the registered manager. The previous interim manager continued to hold the responsibility of the registered manager, pending CQC approval of registered manager status of the hospital director. The hospital director and the registered manager had regular contact. The hospital director continued to be supported by both the registered manager, and the managing director of the company.

This location is registered to provide the following regulated activities:

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

The last inspection was in December 2021. We inspected all five key questions. The inspection also checked compliance against previous enforcement action, which consisted of warning notices for Regulation 12 – Safe care and treatment; Regulation 17 – Good governance and Regulation 18 – Staffing. The inspection team found the service had met the warning notices requirements and had addressed concerns. However, the provider needed more time to recruit more staff and to embed the rehabilitation and recovery model. The hospital was rated requires improvement under each key question. The overall rating therefore following the last inspection in December 2021 was requires improvement.

How we carried out this inspection

This inspection was undertaken with a view to re-rate the service and to see if improvements had been made. We had received numerous notifications from the provider informing us of recent incidents, as well as some feedback from members of the public, which we followed up as part of this inspection.

Summary of this inspection

The inspection team included 1 CQC inspector, 1 CQC senior specialist in mental health, 1 specialist nurse advisor and 1 expert by experience. A medicines inspector joined the inspection for one day. The inspection team kept the CQC operations manager informed of progress throughout the inspection.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider.

During the inspection visit, the inspection team:

- undertook tours of both wards, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 6 carers / relatives of patients
- spoke with 8 patients currently in the service
- reviewed 3 patient enhanced observation records
- reviewed ward ligature risk assessments and mitigation
- observed a morning FLASH meeting
- observed a multi-disciplinary team meeting
- reviewed 12 care records
- spoke with 21 different staff members to include nurses; health care assistant's; a consultant; physiotherapist; occupational therapist; speech and language therapist, speech and language therapy assistant; administration staff; hospital director and the director of clinical services
- reviewed management of medicines across both wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We spoke with 8 people who were using the service and 6 relatives or carers of those using the service.

Three patients told us specifically that staff were kind, caring and supporting. One patient told us the staff were 'absolutely brilliant' and said, 'nothing is too much trouble'.

One patient told us that while they found staff caring during the day, they reported that night staff were not always kind and caring.

One relative we spoke with talked about care during the night for their relative, and expressed concerns as to if there are enough staff to meet the patients' needs and was unsure if staff had received adequate training.

Summary of this inspection

A second carer we spoke with said that night staff would not always respond to call bells in a timely way. We fed this back to the provider.

The physiotherapist had recently started to hold 'open sessions', whereby patients' relatives (with appropriate consent) could sit in on the patients' individual sessions, enabling them to watch progress, and to ask any questions afterwards. We saw some positive feedback the service had received from a relative, who described the session as "very informative".

Patients we spoke with talked about engaging in some activities, such as attending a smoothie making club; gardening; craft groups; quiz's; word searches and Christmas card making.

Four patients were unable to tell us if there were any plans for discharge from the service. One patient knew they had an upcoming meeting where discharge would be discussed.

Patients could keep in touch with friends and family members which they were pleased about. One relative had requested video calls to enable them to see their family member more frequently, which staff had failed to facilitate.

One patient said there was no choice of desserts, staff normally gave out yogurts.

All carers we spoke with knew how to make a complaint and had been updated by staff regularly regarding progress of their relatives.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that staff administering covert medicines are administering these safely.
- The service must ensure that patients who have medicines via route of percutaneous endoscopic gastrostomy (PEG), have care plans in place detailing how staff must administer these.
- The service must ensure that patients are formally assessed under the Mental Capacity Act, with best interests' decisions recorded for those patients where staff deem a lack of capacity to make specific decisions around their care and treatment.
- The service must ensure that any prescribed eye ointments are discarded after 28 days in line with manufacturers guidelines after opening.
- The service must follow the Mental Health Act Code of Practice when caring for a patient in long term segregation.
- The service must ensure all agency staff receive an appropriate induction which is recorded.
- The service must ensure that all agency staff used have been trained appropriately in reducing restrictive interventions, in line with regular staff, provider policy and national guidance.
- The service must ensure they provide psychology as part of therapeutic interventions offered to patients, in line with individual care plans and as part of the rehabilitation model of care.
- The service must have a robust system in place detailing the mandatory training of agency staff, to include levels / type of training and dates undertaken.

Summary of this inspection

- The service must continue to recruit more permanent staff members to improve consistency in care to patients.
- The service must ensure that agency staff can access patient records electronically.
- The service must ensure the hospital is redecorated regularly and staff maintain records to demonstrate this.
- The service must ensure staff follow individual patient care plans around mouth care.
- The service must ensure nursing staff adhere too and record the cleaning and rotation of percutaneous endoscopic gastrostomy (PEG) sites.
- The service must ensure that staff are responsive to patients requests and deal with them promptly and in a respectful way.
- The service must ensure all actions identified following community meetings are followed up by staff and the outcomes fed back to patients.
- The provider must ensure the quality of care is regularly monitored, assessed, and necessary actions are taken to improve care given.
- The provider must consider the use of covert administration of medicines for patients who regularly refuse prescribed medicines.
- The provider must adhere to the Mental Capacity Act before placing unwanted restrictions upon patients.

Action the service SHOULD take to improve:

- The service should ensure a policy and risk assessments are in place for the storage of flumazenil (a reversal agent for benzodiazepine overdose that must be administered intravenously), which staff are aware of.
- The service should ensure that staff undertaking enhanced observations offer meaningful interactions and activities.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

Is the service safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Both wards were safe, clean and fit for purpose. However, they were minimally furnished and needed redecorating.

Safety of the ward layout

Staff completed and regularly updated risk assessments of wards areas and removed or reduced any risks they identified.

Staff could observe patients in most parts of the wards.

The hospital provided mixed sex accommodation which complied with national guidance. Areas of the wards were specifically designated male or female.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Each ward had a specific ligature risk assessment with a visual map indicating risks. Mitigations were in place where appropriate. For example, some areas supervised by staff, or if individual risks were deemed high, enhanced observations would be considered. Both wards had easy access to ligature cutters if required.

Staff had access to alarms which were given out at the commencement of each shift. Patients had access to the nurse call system when in their bedrooms and in other ward areas.

Maintenance, cleanliness and infection control

Ward areas were clean, minimally furnished and fit for purpose. Some furnishings in communal areas were sparce, making some areas clinical looking and uninviting. Both wards needed redecorating and there were numerous small maintenance jobs that needed attention. For example, some small holes in walls which needed filling following taking down of pictures / notice boards. There were several areas across both wards with peeling paint. Numerous doors and walls had scuff marks. We saw what looked to be water damage to the ceiling in the staff room which was in the process of being refurbished by the maintenance team.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were sourced through an external agency and had been working at the hospital regularly.

Staff followed infection control policy, including handwashing. We observed one patient being nursed under enhanced infection control measures due to a potential infection risk. Staff had appropriate personal protective equipment available and used these in line with provider policy.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked the emergency bag visually daily and recorded weekly checks.

Staff regularly checked, maintained, and cleaned medical equipment.

Staff monitored and recorded the room and fridge temperatures in areas where medicines were stored, and informed maintenance if any concerns.

Safe staffing

The service used a high volume of agency healthcare staff to keep people safe from avoidable harm.

Nursing staff

The service did not have enough substantive nursing and support staff to keep patients safe. They continued to rely heavily upon agency staff which increased the risk of people receiving inconsistent care as agency staff were not always familiar with patient's care plans or routines.

Managers had been using 10 care agencies to enable them to cover shifts for ongoing vacancies; short term sickness, training, other absences and to support patients on enhanced observations. We acknowledged that this number had recently reduced to managers using 5 agencies. Managers had to use additional agencies for an interim period, following identification with non compliance with home office working hours under some agencies used. Managers preferred to use agency staff who were familiar with the service and patients, to aid consistency in care, where possible.

Both wards had a ward manager and a deputy ward manager and were actively recruiting further registered nurses and healthcare assistants to boost the establishment. Warwick ward had 2 substantive registered nurses with 4 vacant registered nurse posts. They had 6 senior health care assistants with 2 vacancies. The ward had 6 substantive healthcare support workers, with 14 vacancies.

Cleves ward had 2 substantive registered nurses with 4 posts vacant. They had 6 senior healthcare assistants with 2 vacancies. They had 6 substantive healthcare assistants, with 14 vacancies. The service stated that these shifts were predominantly covered with bank staff and through staff doing overtime. We saw that the hospital had one bank registered nurse and 26 healthcare assistants who worked bank shifts.

Between November 2022 and November 2023, the service had used bank staff to cover 2324 shifts: 191 shifts required a registered nurse and 2133 shifts required healthcare assistants. The number of bank staff used since the last inspection had increased.

Between November 2022 and November 2023, agency staff had covered 14,096 shifts (1412 registered nurse shifts and 12,684 health care assistant). While this was an improvement since the last inspection, agency use remained high.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

This service has had repeated breaches in relation to staffing since registering with the Care Quality Commission in December 2014.

We examined daily staffing sheets which showed that between 1 January 2023 and 3 December 2023, there were a total of 317 shifts which could not be covered through bank or agency staff. Of these, 27 shifts were for healthcare assistants and 290 registered nurse shifts. During this time, all shifts had at least 2 registered nurses working across Warwick and Cleves ward. Managers mitigated against a lack of registered nurses by sourcing additional healthcare assistants to optimise staffing numbers. In addition, ward managers worked Monday to Friday and were available to support the registered nurses on shift if required.

Managers made sure all bank and agency staff had access to a full induction before starting their shifts. However, of 5 agency staff profiles viewed, only 2 had induction paperwork completed and available. Staff said that while all bank and agency staff received an induction, there could be a delay with the paperwork getting from the wards to the administrator, who then uploaded documents to the electronic system. Managers offered all agency staff 2 shadow shifts which entailed working with staff on each of the wards before they were counted in the staffing numbers. If staff are not inducted to the service properly, this could impact upon the quality of care given and have a negative impact upon patient care. Particularly where a service has numerous patients who are vulnerable from a physical health point of view, as well as mental health. This increases the risk of potential avoidable harm.

Staff turnover rates for the service ranged month to month ranging between 0% and 10.5%. Overall, data received from the provider over the past 12 months, showed that turnover for nurses had been 41%, and turnover of healthcare assistants had been 80%, which is high. We noted there had been several promotions of staff within the service. Other staff had left to work in a different care setting.

Managers supported staff who needed time off for ill health and undertook return to work interviews. There were no staff off on long-term sickness at time of inspection. Most episodes of sickness had been short term, for minor physical conditions. Over the last 12 months, 301 shifts had been lost through sickness. Sickness rates had varied month to month, ranging between 3% and 7%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. At the time of inspection, base line staffing (excluding additional staff for enhanced observations), was 2 registered nurses per shift on each ward, with 6 healthcare assistants on Warwick, and 5 on Cleves ward. At night, the baseline was 2 registered nurses on each ward, 4 healthcare assistants on Warwick, and 4 healthcare assistants on Cleves.

The ward manager could adjust staffing levels according to the needs of the patients, for example to accommodate hospital visits, outings or to accommodate further enhanced observations.

Patients had regular one- to-one sessions with staff. Patients rarely had their escorted leave or activities cancelled. Where necessary, ward managers sourced additional staff in advance to facilitate escorted leave.

The service had enough staff on each shift to carry out any physical interventions safely. However, we could not be assured that all agency staff had received the same training in reducing restrictive practise as substantive staff. Agency staff profiles offered no details upon which course had been completed, where they had completed through their agency. We were concerned that different members of staff may have received different training around this, which could cause confusion and in the worst-case scenario unintended injury to self or patients. This was not in line with the provider policy which stated “a check should be made that agency colleagues have received a similar level and type of training to that which is in place at the Priory group”.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff shared key information at the beginning of each shift to keep patients safe when handing over their care to others. Agency health care assistants did not have access to patient electronic records. Therefore, they relied upon a comprehensive handover and updates from regular staff.

Medical staff

The service had 1 full time substantive consultant and 1 locum doctor at the time of inspection. Medical staff provided necessary cover across the 2 wards. A doctor could attend the hospital quickly in the event of an emergency. Managers used locums when they needed additional medical cover.

Managers made sure any medical locum staff had a full induction and understood the service before starting at the hospital.

Mandatory training

Staff had completed and kept mostly up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. This included but was not limited too basic life support; infection prevention and control; safeguarding of adults and children; moving and handling; restrictive interventions training; Mental Health Act; Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored mandatory training and alerted staff when they needed to update this. Most substantive staff were up to date with mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves. Staff used the least restrictions where possible when anticipating, de-escalating and managing people expressing feelings or an emotional reaction. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Management of patient risk

Regular staff knew about main risks to each patient and acted to prevent or reduce risks. These were discussed at each handover.

Staff identified and responded to any changes in risks to, or posed by, patients. The hospital held a daily flash meeting, attended by senior staff and ward representatives. During which incidents, risks and any arising concerns were discussed, and actions identified for completion.

Staff followed procedures to minimise risks where they could not easily observe patients. For example, staff might monitor patients more closely if in areas of the ward with reduced visibility.

Staff were aware of provider policies and procedures if they needed to search patients or their bedrooms to keep them safe from harm. Managers included this as part of the induction process for all new staff.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed.

Incidents of restraint had been relatively low over the last 12 months. On Cleves ward, incidents of restraint had varied between 3 and 13 per month. The total number of restraints used on this ward over the 12-month period was 109.

On Warwick ward, numbers of restraint over the past 12 months had been between 4 and 17 per month. The total number of restraints used on this ward over the 12-month period was 132.

The provider reported 1 incident of prone restraint (chest down) in April 2023. Upon further exploration of this, we found that the restraint had been undertaken initially by 1 staff member, a second staff member who was present assisted once a regular staff member attended the incident. The regular staff member attended following an alarm raised and immediately instructed both staff to withdraw holds. One staff member was agency, and 1 was bank, recently transferred from agency. Neither had received the Priory restrictive interventions training. Managers booked the 2 staff members on this. Documentation seen relating to this stated the prone restraint lasted for 2 minutes. This lack of training had placed patients at significant risk of avoidable harm.

Staff we spoke with understood the Mental Capacity Act definition of restraint and worked within it, in line with the provider's reducing restrictive practice training.

There had been a total of 10 incidents of staff using rapid tranquillisation over the past 12 months. Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation, and only administered this following discussion with the doctor.

Staff had failed to follow best practice, including guidance in the Mental Health Act Code of Practice when a patient was nursed in long-term segregation. Staff had not recognised this as an episode of long-term segregation, despite this continuing for 5 months, with the patient not being freely able to mix with other patients on the ward. Therefore, staff did not record, or treat this as long-term segregation. Best practice ensures the patient has safeguards in place, such as informing the Local Authority and Care Quality Commission of this practice; it is expected that members of the multi-disciplinary team hold regular internal reviews, as well as obtaining independent external reviews, and a clear plan for the patient to be re-integrated back onto the ward at the earliest opportunity, when it is felt safe to do so. Additionally, the provider had breached the patient's human rights under Article 5 of the Human Rights Act (1998).

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Clinical staff received level 2 and level 3 safeguarding training, in line with national guidance.

The hospital had a safeguarding lead in the absence of a social worker, who had received training at level 4. The hospital director had also received level 4 training.

Staff kept up to date with their safeguarding training. All clinical staff during induction received mandatory training in the safeguarding of adults and children. At the time of inspection, staff compliance with safeguarding of adults and children was over 90%.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. The hospital had different rooms off the wards to receive visitors.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had completed safeguarding referrals appropriately to the Local Authority and had informed CQC of incidents whereby safeguarding concerns had been identified.

Staff access to essential information

Not all agency staff had easy access to clinical information. Agency health care support staff did not have electronic access to care records. If they witnessed an incident, they wrote this on a paper form and handed it to other staff who had electronic access to transfer onto the system. We were concerned that important information regarding patient care could be missed, or not reported due to this. Particularly when shifts covered had a high ratio of agency healthcare staff. Most patient records were electronic, although we did observe that some additional patient information had been printed off and placed in folders for staff undertaking enhanced observations.

Patient records we viewed appeared to be up to date and held relevant information around current care and treatment.

If patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Medicines management

The service did not always use systems to safely administer medicines. However, the service did have systems to prescribe and record medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff did not always follow systems and processes to administer medicines safely.

The service used electronic prescribing and medicines administration system. We looked at records for 2 patients who were administered their medicines covertly by staff (disguised in food and drink). There was no available guidance from the pharmacist on how these medicines should be crushed for safe administration. This placed patients at risk of avoidable harm. Additionally, capacity assessments and / or best interests decisions were not available to demonstrate any assessment of patient's capacity to make decisions about receiving their medicines covertly had been considered.

We looked at records for 2 patients who were being administered their medicines by staff via a PEG tube (percutaneous endoscopic gastrostomy – a tube passing through the abdominal wall for feeding and administration of medicines). Care plans for these patients did not detail how medicines should be administered. This placed patients at risk of avoidable harm.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

A pharmacist visited the service weekly and reviewed all medicine charts. Patients' treatment plans were discussed by staff monthly in multidisciplinary meetings. However, we saw 1 patient had not been formally assessed under the mental capacity act with a best interests' decision about their consistent refusal for treatment.

Staff completed medicines records accurately and kept them up to date. We looked at 12 records for patients and saw that all medicines were given by staff as prescribed, recorded accurately and there were no missed doses without a documented reason. Staff recorded allergies clearly on records and each patient had a profile with information on how they liked to take their medicines.

Staff stored and managed prescribing documents safely. However, staff did not always store and manage medicines safely. We saw a bottle of eye ointment which had expired and had been administered to a patient. This placed the patient at risk of ineffective treatment of their eye condition. We raised this with staff who discarded the medicines immediately.

The service stored the emergency medicine flumazenil (a reversal agent for benzodiazepine overdose that must be administered intravenously). Managers told us that this was kept at the service for paramedics to administer if necessary. However, nursing staff were unaware that this was stored. A policy was in place which detailed that suitably trained staff should only manage emergency equipment and medicines. Staff need to be aware that this medicine is stored, and be clear what actions to take in the event it needs to be administered.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice. There was a good culture around reporting of medicines related incidents. Managers investigated incidents appropriately and learning cascaded through various clinical and patient safety meetings.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. We looked at a record for one patient with diabetes. There was a comprehensive care plan in place to support staff looking after this patient and when to escalate concerns.

Track record on safety

The service had improved it's track record on safety from previous inspections.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with knew what incidents to report and how to report them. Agency health care assistants had to rely upon other staff to complete forms electronically. Managers ensured agency healthcare staff had paper forms available so they could capture information which staff would then transfer to the electronic system.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers held weekly safety meetings, with the emphasis being upon learning from recent incidents across the hospital. Staff reviewed any themes of incidents, as well as including what actions staff had taken following reported incidents, such as updating care plans and risk assessments, or reported issues to maintenance staff for attention. Ward managers ensured any relevant cascading of information / learning to staff was actioned.

Staff reported any serious incidents clearly and in line with provider policy. Over the past 12 months there had been 2 serious incidents related to physical ill health.

One occurred in December 2022. Senior staff completed internal investigations in line with provider policy and relevant partners informed. Lessons were learnt and shared. There was ongoing Coroner involvement with a scheduled inquest early in 2024.

The second incident also occurred in December 2022. Senior staff completed internal investigations in line with provider policy and relevant partners informed. An inquest had been held.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We saw an example of this in the form of a letter which staff had sent to a relative following a recent medicines error.

Managers investigated incidents. Patients and their families had the opportunity to have involvement and receive feedback during the investigation process.

Staff received feedback from investigation of incidents, both internal and external to the service. Information was shared through team meetings, ongoing supervision or through provider bulletins.

Staff met to discuss the feedback and look at improvements to patient care. Weekly patient safety meeting minutes recorded lessons learnt which were shared with staff.

Is the service effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised and holistic.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff developed a comprehensive care plan for each patient to meet their mental and physical health needs.

Care plans viewed were personalised and holistic.

Best practice in treatment and care

Staff provided some care and treatment for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives. Staff supported patients with daily self-care.

Psychological therapies were not routinely offered due to no psychology staff in post, although the managers were able to access agency psychological support if required. We saw that psychological support and interventions were present in 4 patients care plans, yet they had not received psychological support as expected. We were unsure how long the hospital had been without a psychologist, some staff said 1 year, another staff member told us it had been 2 years.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff identified patients' physical health needs and recorded them in their care plans. However, not all care plans were being followed. For example, we saw that 1 patient required hourly mouthcare. We noted staff had not recorded any mouthcare for a period of 5 hours on 20/11/2023 and had not recorded mouthcare for 1 hour on 21/11/2023. A second patient required hourly mouthcare, staff had failed to record this for a 2-hour period on 20/11/2023, and a further 1 hour on 21/11/2023. Staff had also failed to record cleaning and rotation of a PEG site for 1 patient in 5 days in November 2023.

Staff made sure patients had access to physical health care, including specialists as required. The hospital had a visiting GP who visited the service regularly and reviewed patients weekly. Patients were supported to attend external hospital appointments. Staff supported patients to attend podiatry and dental appointments as and when required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. The speech and language therapist and assistant provided support with dysphagia problems (swallowing certain foods and / or liquids) and assisted staff with patients with communication difficulties. The service did not have a dietitian to support the nutritional needs of patients with dietary requirements employed at the time of inspection. Managers could access dietetic support from other Priory hospitals.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff had given advice about healthy eating choices. Patients could be prescribed nicotine replacement therapy as part of smoking cessation support offered.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example: the national early warning score, which is a tool which improves the detection and response to clinical deterioration in adult patients and improves patient outcomes, was used routinely by nurses. Occupational therapy staff used tools such as The Model of Human Occupation screening tool (MOHOST) to assess patient motivation, communication, and motor skills. They also used the Functional Independence Measure (FIM) which is a tool used to assess a patient's level of disability.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Clinical audits undertaken regularly included medicines audits; care plan audits and mattress / equipment audits.

Managers used results from audits to make improvements. Staff told us that care plans had improved and had become more personalised.

Staff supported patients with daily self-care.

Skilled staff to deliver care

The ward teams did not have access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide the care required. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the patients on the ward. The service had no social worker, no psychologist nor a dietitian at the time of this inspection. The hospital employed a full-time physiotherapist, who had one assistant. The hospital also had a full-time speech and language therapist, who had one assistant. The hospital had one lead occupational therapist with 3 assistants. The lead occupational therapist did not have a second occupational therapist to support them in their role. They had upskilled their assistants to be able to help complete some assessments such as cooking, community access and budgeting. Assistants had some limitations, for example in cognitive assessments. While they were able to undertake these, the occupational therapist needed to score and interpret the findings to ensure accuracy. The lead occupational therapist completed mostly tasks-based work with patients as expected. In addition to this, they had to attend relevant clinical and management meetings; undertake equipment audits and supervise and support three assistants. While we observed this was manageable with the number of patients at time of inspection, we were concerned that if the occupancy increased, the occupational therapist may find it difficult to meet all needs of all patients.

Managers gave each new substantive staff member a full induction to the service before they started work. This included undertaking some mandatory training, becoming familiar with policies and procedures, as well as spending some time on each ward with staff and patients.

Managers supported all substantive staff with regular, clinical supervision and annual constructive appraisals of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Meetings were held weekly and were recorded.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a healthcare assistant who was training to become a nurse, supported by the hospital. The physiotherapist was encouraged to attend courses and conferences to continue their continuing professional development.

Managers made sure staff received any specialist training for their role. The Speech and language therapist was upskilling to become trained specifically in dysphagia. The hospital ensured they had regular supervision weekly facilitated by a suitably qualified supervisor, which would continue until competency was achieved.

Managers recognised poor performance, identified the reasons and dealt with these accordingly. Where staff members had not acted in a professional or a safe way, appropriate action was taken in line with hospital policy, with support from human resources if appropriate, to address the concerns identified.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to minimise any gaps in patient's care. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations. We saw a commissioner visit a patient during the inspection who met with staff to discuss progress.

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

Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. One patient had been nursed in long-term segregation for five months. Staff had failed to follow the Mental Health Act Code of Practice.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Despite staff receiving training on the Code of Practice, staff did not demonstrate an understanding of long-term segregation. The patient did not have documented reviews in line with the Code of Practice, had no independent external reviews, and did not have a care plan demonstrating re-integration back into the ward main ward area with co-patients.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. The hospital had a Mental Health Act administrator who could be contacted by staff for advice and guidance.

Staff knew who their Mental Health Act administrator was and where they were located on site.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy. An independent advocate held weekly drop-in sessions every week.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The Mental Health Act administrator kept a track on when staff had completed this and noted when staff needed to re-visit with the patient.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Informal patients knew that they could leave the ward freely and each ward displayed posters to remind them of this.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff did not always support patients to make decisions on aspects of their care for themselves.

Staff received and kept up to date with training in the Mental Capacity Act. However, several staff members we spoke with (health care assistants) could not tell us the overriding principle of the Act (to assume capacity unless proven otherwise), which was a concern due to the vulnerable patient group.

Staff had made 12 Deprivation of Liberty Safeguards applications made in the last 12 months. Staff made applications for a Deprivation of Liberty Safeguards order only when necessary. The Mental Health Act administrator kept an up-to-date record of applications made and followed these up accordingly.

There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could access.

Staff did not always give patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. For example, we saw staff were giving medicines covertly to two patients, with no evidence of a capacity assessment and / or a best interests decision.

We saw 1 patient had not been formally assessed under the mental capacity act with a best interests' decision about their consistent refusal for treatment. This was a concern due to the nature of the medicines prescribed. Non concordance with medicines had contributed to seizure activity, which was potentially unavoidable.

Staff assessed and recorded capacity to consent related to some decisions for some patients but not all. For example, we saw a capacity assessment and a best interests decision recorded in relation to staff attending to some aspects of a patient's personal care, and further documented assessment and best interests' decision around the use of bed rails. Yet we failed to locate capacity assessments relating to covert administration of medicines.

Is the service caring?

Requires Improvement

Our rating of caring stayed the same. We rated it as requires improvement.

Kindness, privacy, dignity, respect, compassion and support

Most staff treated patients with compassion and kindness and respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

We spoke with 8 patients. Four of these told us that staff were kind, caring and supportive. One patient said while the day staff were kind and supportive, not all staff who worked at night were. During inspection, we observed some discreet and respectful interactions between staff and patients across both wards.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help. For example, to external healthcare professionals.

Most patients said staff treated them well and behaved kindly. We observed numerous positive and kind interactions between staff and patients during inspection. However, 1 relative told us of a recent incident when their family member had asked staff if they could be assisted to the toilet and was told to 'use their pad'. Managers were aware of this and reminded staff to think about language used and to promote continence of all patients. Another carer told us that their relative had been 'left in an incontinence pad by night staff'.

Some concerns were raised with us from 1 relative about the time it could take for staff to respond to call bells. This was fed back to the director of clinical services. While it was possible for the service to request and print off bell ringing and staff response times, it was not possible for staff to complete this onsite.

We reviewed some enhanced observation records and observed some staff on enhanced observations during inspection. We identified that staff were not always engaging with the patients in a meaningful way. Records seen recorded where the patient was and if they were awake or asleep. There was nothing in regard to activities offered or undertaken or recorded general interactions.

Staff we spoke with felt that they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients, to more senior staff and / or the hospital director.

Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment where possible and actively sought their feedback on the quality of care provided but did not consistently act upon this. Staff ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward, services, and staff as part of their admission.

Staff involved patients where possible and gave them access to their care planning and risk assessments.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. We saw numerous easy read documents on the wards. We saw some positive behavioural support plans. We also observed different ways staff communicated with patients, for example, writing on a whiteboard, using pictorial aids, electronic devices, as well as using some basic hand gesturing.

Staff involved patients in decisions about the service, when appropriate. For example, staff had tried to create a 1950's style dining area on Cleves ward following feedback from patients.

Patients could give feedback on the service and their treatment and staff supported them to do this. However, staff failed to consistently record actions taken following feedback from community meetings. As an example, in April 2023, a patient had raised that some night staff were disrespectful. In the next meeting in May this had not been acknowledged

by staff with no actions recorded. A different patient spoke about some staff negatively in May 2023 during the community meeting. While staff were recording patients' views, we were not confident staff took appropriate actions and offered feedback. Staff had recorded some updates for specific requests, such as requesting more outings, or ordering of games equipment. Some of which had been displayed on "You said, We did" boards.

Staff supported patients to make decisions on their care. Staff ensured patients could access advocacy services. The hospital had a visiting independent advocate who visited weekly, providing drop-in sessions for patients across both wards.

Involvement of families and carers

We spoke with 6 family members and / or carers of patients who were using the service.

Staff informed and involved families and carers appropriately.

All said staff kept them updated in care and treatment offered where the patients had given consent to do so. This included any planning for discharge. Most carers said they received monthly updates as standard but could call the hospital at any time for an update.

Two of the 6 carers we spoke with said visiting regularly was difficult, due to the distance and travel time. For 1 relative, it was a 3 hour journey each way. One carer had asked the service if they could facilitate video calls, so that they could see their relative more frequently. The relative informed us that this had not been facilitated by hospital staff and was unsure why this was.

Two carers talked about being unsure if all staff had the skills and knowledge to care for the patients and meet their needs. This was raised by 2 different carers, referring to the care and treatment of 2 different patients, and spoke specifically about staff during the night.

Is the service responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

Access and discharge

Staff planned and managed patients discharge. They worked with services providing aftercare to plan patients' move out of hospital. However, there had been delayed discharges within the service primarily due to the lack of a suitable placement.

Managers made sure bed occupancy did not go above 85%. The average occupancy over the last 12 months had been 47%. This was partly due to the temporary closure of Dalby ward.

Managers regularly reviewed length of stay for patients. Despite this, some patients had been at the hospital for many years, the longest being 9 years. We therefore could not be confident that all patients did not stay at the hospital no longer than they needed to.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service had some patients who were some distance from relatives, making it more difficult to achieve regular visits. Managers were flexible with visiting and considered visitor's travel time.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. For example, if there had been a safeguarding concern raised.

Staff did not move or discharge patients at night or very early in the morning. Staff planned discharges at an appropriate time of day and ensured transportation and aftercare were in place.

The psychiatric intensive care unit had beds available if a patient needed more intensive care. No patients had required any transfers to an intensive care ward in the 12 months preceding inspection.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and knew which wards had the most delays, along with the rationale for the delays. Over the past 12 months, the hospital had reported a total number of 11 delayed discharges. Reasons for these varied between a change in circumstances resulting in minor delays, funding issues, lack of a suitable placement, and delays in building / refurbishing of onward placements.

At time of inspection, there were 4 delayed discharges, relating to funding issues and / or suitable placement availability.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. We observed an MDT meeting during which staff had planned imminent discharge.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design and layout of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients who were able could make hot drinks and snacks at any time. When clinically appropriate, staff could support patients to self-cater.

Each patient had their own bedroom, which they could personalise if they wanted. We saw some personal effects and family photographs in some bedrooms.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The physio had a working space with different equipment enabling the ongoing assessment and treatment of patients. The occupational therapist had a kitchen they could use if completing some kitchen assessments or basic cooking tasks.

The service had quiet areas and rooms just off each ward where patients could meet with visitors in private.

Patients could make phone calls in private and were able to use mobile phones.

The service had an outside space that patients could access. The hospital had two lifts, one large enough to facilitate different mobility equipment.

Patients could make their own hot drinks and snacks if they were able and were not dependent on staff. Patients could use the nurse call bell system to request snacks or drinks if they were unable to attend to this independently.

The service offered a variety of food although some staff and patients said there was a lack of choice of desserts.

We observed 2 mealtimes during inspection and saw very limited interactions between the staff present with the patients. We observed many patients were provided with meals in their bedrooms and were supported to eat by staff. The dining areas were quiet, with little atmosphere. No music was offered in the background, staff did not set any tables and there were minimal pictures within the dining areas.

Patients' engagement with the wider community

Staff supported patients with some activities outside the service, such as visits to local places of interest, or to facilitate family visits.

At the time of inspection, staff supported patients with activities out of the service, such as trips to a garden centre or to the local town to obtain shopping. We were unaware of any patients who had been engaging in work or educational activities outside of the hospital.

Staff helped patients to stay in contact with families and carers. Visits were encouraged where possible. Managers had identified that some families had a long journey when visiting. They had secured a reduced rate with two nearby hotels which families could utilise.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of patients, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service supported and made adjustments for disabled people and those with communication needs or other specific needs. Wards were spacious with corridors being suitable for mobility equipment. A range of communication aids were available. Internal lifts accommodated mobility aids.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service had produced some information leaflets available in languages spoken by patients where their first language was not English.

Managers made sure staff and patients could get help from interpreters or signers when needed. One patient had a regular interpreter on a weekly basis to relay information between the staff team and the patient.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Kitchen staff provided meals in various consistency, in line with individual care plans.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients had access to spiritual, religious, and cultural support. If able patients could visit local places of worship. Patients also had access to a visiting chaplain, as well as a dedicated space within the hospital for prayer and reflection.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew how to handle complaints and where to record them.

Managers investigated complaints and identified any recurring themes. The service had received 5 complaints over the past 12 months. Three of these were in relation to the Mental Health Act and restrictions, and two were regarding care and treatment. Managers had investigated these, and responses had been sent to those who made the complaints in line with provider policy.

Staff protected patients who raised concerns or complaints from discrimination and harassment from others.

Staff knew how to acknowledge complaints and patients received feedback from managers after investigations into their complaint had been completed.

Managers shared feedback from complaints with staff and learning was used to improve the service where possible.

The service used compliments to learn, celebrate success and improve the quality of care. The service had recorded 53 compliments over a 12-month period. These ranged from feedback from patients and relatives; student nurses who had worked at the service and positive feedback from commissioners.

Is the service well-led?

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. However, they were a new leadership team who needed time to become cohesive and drive forward improvements. They were visible in the service and approachable for patients and staff.

The senior leadership team were relatively new in post. The hospital director, director of clinical services and one ward manager had been in post less than 12 months." However, the director of clinical services and ward managers had worked at the hospital in different roles and so knew the hospital well. It was evident that they continued to make progress in developing a visible and supportive team.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

Staff we spoke with knew that the overarching aim of the hospital was to provide good care and treatment, assist and support patients with daily activities of living, and to help develop skills to optimise the chance of discharge into the community (where possible).

The new leadership team were in the process of developing the hospital strategy. During interviews with senior staff, it was unclear what the future plans were for the hospital. Dalby ward was closed and there had not been a decision on what the function of this would be in the future, although there had been some discussions around this.

Culture

Staff felt respected, supported, and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff we spoke with were happy in their roles and enjoyed working at the service. Many staff were clearly very passionate about making a difference to people's lives, in line with the values of the service. Leaders should ensure that there is a healthy and positive culture and set clear expectations with the staff team.

Staff told us they could raise concerns to senior staff without fear of reprisal. Staff spoke highly of the director of clinical services and the hospital director, both of whom were reported as visible and approachable. The hospital had a 'Freedom to speak up Guardian' which enabled staff to voice concerns anonymously if preferred.

Agency healthcare staff and bank staff we spoke with were happy working at the service and said they were treated like regular staff.

We saw the hospital produced monthly bulletins which shared general news and updates. This included a 'employee of the month' who received a token of appreciation in the form of a gift.

Governance

Our findings from the other key questions demonstrated that governance processes were in place but were not sufficiently embedded to ensure consistent oversight of quality of the service.

Senior staff were aware of some issues that needed to be addressed and were in the process of implementing and developing systems to monitor and improve these.

Senior staff acknowledged re-decoration and some updating of furniture was needed, but this had not been actioned in a timely way. This was clear for people to see as they walked through the wards, which senior staff made a point of doing regularly. Staff we spoke with told us that the maintenance staff did redecorate and attend to minor jobs as reported, but said that within a few weeks, marks would again re-appear on walls and doors. While plans were in place to redecorate and complete aesthetic tasks, there was no rolling redecoration plan in place. Some issues had been outstanding for some time. We reviewed the Warwick ward action plan: maintenance, dated 16/11/2022. Two items

were still outstanding. These related to areas which needed painting (sensory wall and downstairs dining room). The Cleves ward action plan was dated 20/11/2022 and had many actions outstanding. This included walls needed minor repairing and painting following removal of notice boards, areas of peeling paint, holes in walls and water marks on a ceiling.

Maintenance logs reviewed demonstrated the team had been responsive to requests. However, the log was not as detailed as it could have been. For example, the log stated that work had started in a particular bedroom, but it did not state what that work was, or recorded details about the progress.

Recruiting and retaining permanent staff had been an area of concern highlighted at previous inspections. While there had been some increase in the use of bank staff, agency use remained high. Agency staff profiles viewed were not as detailed as they could be. For example, mandatory training was indicated by a tick box, with little detail. Staff had received safeguarding training, but the level of this was not indicated. Agency staff had completed training in restrictive interventions, but not necessarily the same training regular staff received. Therefore, we could not be assured that the training was in line with provider policy or national guidance. This was a concern due to the volume of agency staff used.

Agency healthcare assistants did not have access to the electronic records system. Agency registered nurses did and could input information as relayed. This meant that healthcare assistants could not access all patient information easily, nor could they immediately record any incidents or significant information. We were unaware of any plans managers had to address this.

There was a clear process for agency and bank staff to receive an induction to the service prior to commencing shifts. However, this was not robust, with some staff having completed the induction, having no evidence of this within their online files.

Not all staff we spoke with understood mental capacity which is concerning as this could lead to patients not always being given a choice regarding some aspects of their care and treatment.

Despite the service having medicines audits and care plan audits in place, we identified some issues relating to both which had not been identified by the hospital's audits. Audit processes were not effective. Issues of concerns identified during inspection, demonstrates systems and processes in place to monitor risk and the quality of the service was ineffective.

The hospital has been found to have repeated breaches of the Health and Social Care Act 2008 since being registered with the Care Quality commission in December 2014, which has led to enforcement action being taken, with ratings of either Requires Improvement or Inadequate. Notably, there have been repeated breaches under Regulation 12: Safe care and treatment; Regulation 17: Good Governance and Regulation 18: Staffing. There has been little evidence of sustained improvement in the quality of this service.

Management of risk, issues and performance

Not all agency health care assistants had access to the information they needed to provide safe and effective care and use that information to good effect.

Regular staff could access information easily. However, not all agency staff could. This was not reflected in the hospital risk register.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Ward managers had access to data around training, sickness, supervision and appraisals. This enabled them to keep a track of where the staff team were at in terms of compliance and expectations.

Members of staff could raise concerns and issues with their ward managers, who could access the risk register and could discuss risks during internal governance meetings. The main risk staff talked about was the number of clinical vacancies resulting in high use of agency staff. This was an active high risk on the hospital risk register and had been since March 2023.

Areas of risk, issues and performance were discussed in different forums. Staff meetings; supervision, multidisciplinary meetings; daily hospital flash meetings and weekly safety meetings. All of which fed into the clinical governance meetings.

Staff notified and shared information with external organisations. Staff were open and transparent and explained to patients when something went wrong.

Staff were offered the opportunity to give feedback and input into service development. Both ward managers had put together a maintenance action plan for their wards, which highlighted areas of the ward which required improvement and the rationale for this.

Due to issues found on inspection, we did not feel that oversight of risk was effective or robust. Further work is required in this area to regularly monitor and identify risks, and take actions to mitigate against these.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Not all staff had timely access to information they needed to provide safe and effective care.

Managers were equipped with relevant information so they could monitor key performance indicators and address any issues in a prompt way.

Staff had not always notified and shared information with external organisations when necessary. Managers failed to ensure a notification was sent to the Care Quality Commission and the Local Authority during an episode of long-term segregation which continued for months.

Information governance systems included a policy around the importance of confidentiality of patient records.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

Managers from the service participated in the work of the local transforming care partnership.

Due to the inconsistent feedback given to patients following community meetings, we felt managers had missed some opportunities for effective engagement, which failed to demonstrate a commitment to addressing issues raised.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We were not given any evidence of the hospital working closely with the immediate local community to benefit patients in their recovery journeys, in preparation for discharge.

Learning, continuous improvement and innovation

The physiotherapist had recently started to hold 'open sessions', whereby patients' relatives (with appropriate consent) could sit in on the patients' individual sessions, enabling them to watch progress, and to ask any questions afterwards.

This had been well received and gave family members the chance to see real progress in real time. We noted that a relative gave the service some positive feedback following observing a session in September, describing attending as 'very informative'.

Another family member thanked the physiotherapy staff after observing a session in September, stating it enabled them to 'mark progress to date'.

Managers supported placements for student nurses across the hospital and had received some compliments relating to the learning and development of the students while at Burton Park.

The hospital were members of the United Kingdom Acquired Brain Injury Forum (UKABIF), which is a membership organisation with resources available to members in areas of clinical practice related to head injury.

The hospital had made some progress with improvement since the last inspection, but it was clear further work needed to be done, with emphasis upon regular monitoring of quality and the implementation of more robust systems and processes.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider had failed to follow the Mental Health Act Code of Practice during the long-term segregation of a patient. • The provider had failed to ensure a capacity assessment had been completed or a best interests decision made (if appropriate) prior to restrictions on the use of a patient's electronic cigarette (vaporiser) being put in place. • The provider had failed to adhere to the Mental Capacity Act when choosing to administer medicines covertly.

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 • The provider did not ensure all staff respond to patients requests in a timely way.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The provider had not ensured all agency staff had received appropriate restrictions intervention training. • The service did not have a psychologist in post. • The service had not ensured all agency staff had evidence of receiving an induction to the service.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not have a robust system in place to monitor the mandatory training agency staff had received, to include levels / type of training and dates undertaken. • The provider had failed to ensure all agency staff had access to patient electronic records. • The provider had failed to ensure actions from community meetings had been actioned and fed back to patients. • The provider had failed to ensure the quality of care provided was regularly monitored, assessed and steps were taken to improve the quality and safety of care given. • The provider had continued to use high volumes of agency staff due to ongoing clinical vacancies, impacting consistency of care to patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The provider did not have a robust, ongoing re-decoration plan in place across the hospital.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The provider had failed to ensure staff adhered to the Mental Capacity Act with regards to patients who lacked capacity to consent to certain aspects of treatment.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider had not ensured staff had adhered to care plans in relation to the cleaning and rotation of percutaneous endoscopic gastrostomy (PEG) sites. • The provider had not assured all staff adhered to care plans relating to mouth care. • The provider was unaware an eye ointment being administered should have been discarded, in line with manufacturers guidelines. • The provider had not ensured patients who were administered medicines via a percutaneous endoscopic gastrostomy (PEG tube) had detailed care plans instructing staff how to safely administer these. • The provider did not ensure staff were administering covert medicines safely. • The provider had failed to consider covert administration of medicines for a patient, despite ongoing non-concordance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure the Mental Health Act Code of Practice (1983) had been followed during an episode of long-term segregation between April and September 2023. The provider failed to recognise this as long-term segregation and therefore did not adhere to the Mental Health Act Code of Practice (1983) to safeguard the patient and demonstrate this was the least restrictive option available which ended at the earliest opportunity. The provider failed to follow the Mental Capacity Act (2005) in relation to restrictions placed upon a patient. The provider had failed to ensure a formal assessment of mental capacity had been completed or a Best Interests decision prior to these restrictions. The restrictions placed upon the patient had a negative impact upon them, and had affected routine care given. The provider failed to adhere to the Mental Capacity Act (2005) upon choosing to administer medicines covertly for two patients. There was no evidence of a capacity assessment / Best Interests decision. The patients did not have their thoughts and wishes taken into consideration and there was no rationale that covert administration was proportionate in response to the potential risk of harm of the patients not receiving prescribed medicines.