Partnerships in Care Limited

Burton Park

Inspection report

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Date of inspection visit: 21 March 2021
Date of publication: 10/06/2021

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?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inadequate

Summary of findings

Overall summary

This focused inspection was completed because we received information giving us concerns about the safety and quality of the care at Burton Park. At our last inspection we rated the provider overall as requires improvement.

This was a focused weekend inspection. Because of its limited scope, we did not rate each key question at this inspection. You can view previous ratings and reports on our website at www.cqc.org.uk.

Following the inspection CQC immediately issued an urgent enforcement section 31 letter of intent to address the identified areas of concerns. We issued three warning notices:

- Regulation 12, (1) Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Regulation 17, (1) Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Regulation 18, (1) Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

As a result of this inspection the rating for this core service has been changed to inadequate.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We found:

- Staff did not always follow Covid-19 infection prevention and control principles. Whilst managers informed staff of the latest infection control prevention guidance at team meetings, they did not always follow this in practice.
- Managers investigated serious incidents, but staff did not always know and implement the lessons learnt to improve patient safety.
- Patients risk assessments were not regularly reviewed.
- The provider did not maintain patient confidentiality, with patient identifiable information left unsecure in communal lounges
- Managers failed to protect patients from abuse and improper treatment. In addition, managers failed to take actions as soon as they were alerted to suspected, alleged or actual abuse, or the risk of abuse.
- Burton Park had a high use of bank and agency staff and staff vacancies. Managers failed to ensure that they had the required numbers of staffing for patient observations.
- Patients were stopped from leaving the units during the pandemic for community leave to purchase essential items. This was not in keeping with the government guidelines at the time of the inspection.
- Staff did not always treat patients with respect, dignity and kindness. Patients told us they felt some staff were rude. Some patients questioned whether there were enough therapeutic activities to aid their rehabilitation and recovery.

Summary of findings

- The culture across the three units was not positive. At the time of inspection, the culture was not one of fairness, openness, transparency, challenge and candour. Staff and patient feedback were inappropriately filtered or not responded to.
- The leadership at the time of inspection was not robust. Staff told us they were not treated with respect and senior managers did not listen to their views. There was a disconnect between senior managers and staff across the three units.
- Staff did not receive regular supervision with low compliance at 9% in February 2021.
- The leadership team at Burton Park was not stable. The registered manager had resigned, and the clinical director was leaving, and a replacement not yet found. There had been a continued high turnover of senior leadership.
- Managers failed to demonstrate that performance and risk were managed well. Governance processes did not work effectively at unit level.

However

- All three units were generally well equipped, well-furnished and well maintained. Staff completed regular risk assessments of the care environment including a ligature risk assessment.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. We saw staff on Cleves Lodge manage one patient's challenging behaviour in a calm manner.
- Mandatory training was compliant at 87%. Managers held a fortnightly safeguarding meeting which triangulated safeguarding referrals, incident data and actions.
- Patients had a choice of food to meet dietary requirements. We observed mealtimes across the three units and saw a range of food prepared for tea including bread rolls, sandwiches and cakes.
- Staff monitored and reviewed patient's physical health care needs. Staff held weekly community meetings with patients. Patients engaged well with the process.
- Around the service there were posters highlighting phone numbers that staff could call to report bullying and harassment and to whistle-blow. Across the provider there was a dedicated freedom to speak up guardian for the healthcare division.

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 	As a result of this inspection the rating for this core service has been changed to inadequate. See overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to Burton Park

Burton Park provides specialist neurobehavioral rehabilitation, for those with an acquired brain injury, including traumatic brain injury and stroke, or a progressive neurological condition. We inspected three units: Warwick Lodge, Dalby Unit and Cleves Lodge following an anonymous whistleblowing which identified multiple concerns in relation to patient care.

Burton Park has 50 beds across three units. Warwick Lodge is a 15-bed Huntington's disease unit. Dalby Unit is a 9-bed unit for females with an acquired brain injury or a progressive neurological condition. Cleves Lodge is a 26-bed unit for males with an acquired brain injury. It is split over 2 floors, providing 13 beds for acute neurobehavioral rehabilitation and 13 beds for slow stream rehabilitation.

What people who use the service say

- We spoke with 13 patients during the inspection.
- Three patients described reporting incidents to staff about staff behaviour and not receiving any feedback.
- Patients told us that staff were not always respectful or responsive to their needs. Some patients told us staff were rude and not always kind. One patient told us the staff were exceptional, easy to get on with, and support from the therapy team had been beneficial.
- One patient who had been at the service for over six months told us they didn't think the service offered a rehabilitation service. They had three cooking sessions with the occupational therapist and limited time with the activity coordinator; and felt this didn't prepare them for life at home.
- Patients told us there were no community leave or excursions out. One patient told us it was boring and there wasn't enough help them get better.
- There was mixed feedback from patients around meals, one patient said the food was terrible and boring, some patients described the food as awful and poor.

How we carried out this inspection

How we carried out the inspection

This was a focused inspection; we inspected against elements of the following Key Lines of Enquiry:

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

During the inspection visit, the inspection team:

- inspected three units, looked at the quality of the ward environment and observed how staff were caring for patients
- reviewed seven patient care plans
- reviewed seven patient risk assessments
- spoke with 13 patients who were using the service

Summary of this inspection

- spoke with nurses in charge of the shift, a unit manager and one on-call manager for the service
- spoke with 17 other staff members; including nurses, health care assistants, and kitchen assistants
- observed patients during mealtimes on three units
- observed three staff handovers, day staff to night staff on three units
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find further 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.

Areas for improvement

The provider must ensure that:

- The provider must ensure Covid-19 Infection Prevention and Control principles are followed. Regulation 12(1)
- The provider must ensure Food Hygiene standards are followed. Regulation 12(1)
- The provider must ensure patients risk assessment are regularly reviewed. Regulation 12(1)
- The provider must ensure there are enough permanent staff at all levels to manage the service and meet the needs of the patient group. Regulation 18(1)
- The provider must ensure robust procedures are in place and lessons learned from investigation, complaints and safeguarding are shared with staff following incidents and fully implemented. Regulation 17(1)
- The provider must take action as soon as they are alerted to suspected, alleged or actual abuse, or the risk of abuse. Regulation 13 (3)
- The staff team must always treat all patients with dignity and respect. Regulation 10(1)
- The culture across the units must be reviewed to ensure patient care is of a high quality. Regulation 17(1).
- The provider must ensure staff receive regular supervision. Regulation 18(2)
- The provider must ensure patient records are kept secure and confidential. Regulation 17(1)
- The provider must ensure there is regular review of patient observations. Regulation 12(1)

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	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inadequate	Inadequate
Overall	Inadequate	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inadequate

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

During our inspection we became aware of concerns on all three units. We found areas of practice which did not meet the legal requirements and have acted under our enforcement powers. Owing to this, the rating for the safe domain has gone down to inadequate.

- Staff did not always follow Covid-19 infection prevention and control principles. Due to Covid restrictions and social distancing guidance, the provider had determined that only three people could be in the Cleves Lodge reception area at any one time, this was indicated by a sticker in this area. We observed, during the handover from day staff to night staff, eight staff in this area. We observed three staff not wearing face masks correctly (below their chins), leaving the reception area. We had to request a member of staff on Cleves Lodge to adjust their mask, so it covered their nose. Masks held within Cleves Lodge reception area were stored out of a box. We observed staff 'thumbing' through the masks prior to sanitising their hands. The hand sanitiser was on the other side of the reception area. There was no signage to tell staff or visitors to wear masks when entering the hospital. Three staff were not bare below the elbow.
- Staff on Cleves Lodge (upstairs) and Dalby Unit did not sanitise their hands when moving from one activity to another or changing masks when they left the ward area and then returning. Staff did not carry personal sanitiser to use when required. Staff did not sanitise or wipe down tables and furniture after they had been used. We observed, on Cleves Lodge (downstairs) that a patient left the dining area and the table and chair was not wiped down.
- Managers failed to ensure that staff had access to appropriate equipment and facilities to handle food in line with good food hygiene. The only hand washing facility on Cleves Lodge (upstairs) was in the staff toilet. We observed a meal being served to patients and found that staff did not utilise the correct utensils when serving food. Staff tipped food from one plate to the other. Staff failed to wear appropriate hair coverings. We saw refilled jugs placed on the drinks trolley with no lids and the fridge was dirty. We saw cleaning schedules around the units were not completed. In addition, we observed a member of staff returning to the unit after dealing with an incident. The member of staff was visibly hot and sweating. They used wipes to wipe their face and forehead and then proceeded to handle food without washing their hands.
- Managers failed to protect patients from abuse and improper treatment. In addition, managers failed to take actions as soon as they were alerted to suspected, alleged or actual abuse, or the risk of abuse. We spoke with 13 patients and three of these patients reported potential safeguarding incidents. The incidents reported during the inspection were of staff threatening patients and physical assault. The team requested follow up action from the provider in relation to

these incidents including evidence of investigations, safeguarding referrals and Care Quality Commission notifications. The compliance rate was 95% for safeguarding training. From February 2021 there is monthly safeguarding refresher training. Seven staff had trained to enhanced level 3 safeguarding. This includes the safeguarding lead, the ward managers and deputy ward managers.

- Staff did not assess, monitor or manage risks to patients. We reviewed seven risk assessments on Warwick Unit. Staff had not updated six out of the seven patient records regularly. Staff had not identified all patients' individual risks with a risk assessment and made plans to mitigate this risk.
- Staff used mechanical restraint but did not ensure that the risk assessment included the required breaks from the mechanical restraint as outlined in the Mental Health Code of Practice. (Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person, to restrict the person's movement).
- Staff identified that some patients had risks associate with the use of bed linen, however, this had not been recorded in patients risk assessments. Sensory equipment used to support a patient when they were displaying risk behaviours had not been included in the risk assessment. A care plan highlighted that a patient was at risk deliberate self-harm behaviour and suicide, but the risk assessment stated there were no concerns. One patient's advance decision care plan had not been updated since 6 April 2020. A sixth patient's risk assessment confirmed the patient had a physical health condition that needed to be monitored but plans to mitigate risk were not included in their risk assessment.
- Managers failed to ensure that they had the required number of staff to meet the needs of the patients. At the time of our weekend inspection, there was a high use of bank and agency staff. From 1 September 2020 to 24 March 2021 there had been 97 days where the hospital was short staffed. This ranged from one member of staff short to 10 staff. The average number of staff shortages was 2.6 over the 97 days. The temporary staff we spoke with told us they regularly worked at the service and were familiar with the patient group. The provider had an ongoing recruitment strategy with weekly interview slots and assessment centre days. Two new health care assistants started work in March 2021.
- Managers failed to ensure that they had the required numbers of staffing for patient observations. The staff rota confirmed staff observation plans for patients. When we spoke with staff, they confirmed patient observations were generally "set observation levels" with little variation. This meant that patients observations were not consistently arranged in line with the changing need of the patient.
- Patients were stopped from leaving the units during the pandemic for community leave for essential items. This was not in keeping with the government guidelines at the time of the inspection.
- Managers investigated serious incidents but adequate action to manage the lessons learnt were not always taken. We found little evidence of staff learning from events or taking action. Instead we identified that managers had created unrealistic demands on staff around sharing lessons learned. Staff used the patient handover at the beginning of shift to share up to 50 actions that needed to be complied with. In addition, they would have to sign off emails with the same messages sometimes up to four times a day.

However

- All three units were generally well equipped, well-furnished and well maintained. Staff completed regular risk assessments of the care environment including a ligature risk assessment. All staff had access to personal alarms which were tested regularly.
- Mandatory staff training compliance rate was 87%. A learning administrator had plans in place to improve compliance and managers were confident that they will meeting the 95% compliance target by the end of June 2021
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. We saw staff on Cleves Lodge manage one patient's challenging behaviour in a calm manner.
- Managers held a restrictive practice meeting attended by patients and a range of staff from the multidisciplinary team. The agenda was set by the patients and they determined the area of focus. It was evident managers were working with patients to monitor and reduce restrictive interventions across the hospital.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records whether paper-based or electronic.
- In the last two years there had been 17 whistleblowing concerns raised. We reviewed the document and are satisfied that the managers took the appropriate action.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Inspected but not rated

We did not rate effective at this inspection. We found:

- Staff monitored and reviewed patient's physical health care needs. We reviewed a care plan and found that it detailed all the patient's individual healthcare needs with actions staff had to take to support the patient. Staff had assessed the patient's capacity to consent to the care and found that they lacked capacity and therefore completed a best interest assessment.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Inspected but not rated

We did not rate caring at this inspection. We found:

- Staff did not always treat patients with respect and dignity and kindness. Patients told us they felt some staff were rude. Some patients questioned whether there were enough therapeutic activities to di their rehabilitation and recovery.
- Staff held weekly community meetings with patients. The agenda was in an easy read format with pictorial prompts for patients. Patients engaged well with the process. After the meeting staff developed an action plan to ensure that all actions raised were completed within a set timeframe.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Inspected but not rated

We did not rate responsive at this inspection. We found:

- Patients had a choice of food to meet dietary requirements. There was mixed feedback from patients around meals. Staff told us the last meal was a roast dinner, seasonal fresh vegetables and dessert. We observed one mealtime served across the three units and this included bread rolls, sandwiches and cakes

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Inadequate

During our inspection we became aware of concerns on all three units. We found areas of practice which did not meet the legal requirements and have acted under our enforcement powers. Owing to this, the rating for the well-led domain has dropped to inadequate.

- The leadership team at Burton Park was not stable. The registered manager had resigned, and the clinical director was leaving, and a replacement not yet found. There had been a continued high turnover of senior leadership and high vacancy rates for nursing staff. Leaders were failing to keep in touch with what was happening on the front line and failed to act on potential risk issues.
- Managers failed to ensure that staff adhered to Covid-19 infection prevention and control principles. We acknowledged that managers raised issues in team meetings to address infection prevention and control compliance, but this had little impact on staff's compliance.
- Managers failed to ensure that they had the required number of staff to meet the needs of the patients. The service had five qualified nurse and 48 health care assistant vacancies. The provider had an ongoing recruitment strategy with weekly interview slots and assessment centre days. We acknowledged that managers had an escalation plan in place for staff to follow if they are short staffed. However, this process did not mean staff numbers were increased.
- Managers had not developed a positive culture within the service. The culture at the time of the inspection was not one of fairness, openness, transparency, challenge and candour. Staff and patient feedback were inappropriately filtered or not responded to. Managers were defensive and were not compassionate. We were notified of high levels of bullying, harassment and discrimination. We were not assured that the organisation had taken adequate action to reduce this. When staff raised concerns, they were not treated with respect.
- The culture was top-down and directive. During the inspection we spoke with 17 staff. Some staff told our team they did not want to speak with us for fear of retribution. For example, after the Care Quality Commission held virtual staff focus groups in January 2021, we were informed that senior managers had harassed staff about what they had shared in the group. Another staff member said they had seen bullying behaviour from senior managers. There were high levels of stress due to managers putting additional responsibilities on staff and overloading staff. Staff told us when they raised concerns, they were not treated with respect and senior managers did not listen to their views. There was a disconnect between senior managers and staff on all three units. Two staff told us there had been issues with the senior managers team around protected characteristics.
- Managers did not have robust procedures in place to ensure lessons learned from investigations, complaints and safeguarding incidents were shared across the hospital. Managers did not adhere to duty of candour after the death of one patient.
- Managers failed to ensure that staff had access to regular supervision. From April 2020 to March 21 48% of nursing received clinical supervision. The highest level of compliance of supervision was in December 2020 with 90%, the lowest was in Feb 2021 with 9%.

However

- As part of clinical governance managers held a fortnightly safeguarding meeting which triangulated safeguarding referrals, incident data and actions. We reviewed the safeguarding log which was comprehensive and included all actions taken to ensure the safety of the patients within the service.
- Twenty-four serious incidents had taken place within the last six months. All incidents had been investigated with clear action that that the service needed to take to ensure that they did not reoccur.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

- The 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) process was in place and led by the GP and Consultant for the service. There was a log within the service with all the relevant information and where possible there was input from patients and relatives as appropriate.
- Managers appointed investigating officers to investigate complaints within given timescales and in line with the provider policy. From 21 May 2020 to 2 March 2021 there had been five complaints logged. Out of the five complaints, four were partially upheld and one was upheld.
- Situated around the service there were posters highlighting phone numbers that staff can call to report bullying and harassment and to whistleblow. Across the provider there was a dedicated freedom to speak up guardian for the healthcare division.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

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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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

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