Requires improvement

Partnerships in Care Limited

Burton Park

Quality Report

Warwick Road
Melton Mowbray
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Website: www.priorygroup.com/location-results/item/burton-park

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1759782261		Burton Park	LE13 0RD

This report describes our judgement of the quality of care provided within this core service by Burton Park. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Burton Park and these are brought together to inform our overall judgement of Burton Park.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Burton Park as requires improvement because:

- Staff did not follow the provider medicines management policy. We found three tubes of topical creams in the fridge on Warwick Lodge which staff had opened but had not labelled with the patient's name.
- Managers did not ensure there was adequate medical cover to prescribe essential medication. One patient had been admitted to the hospital when no medical cover was available. Therefore, essential medication had not been prescribed and the provider could not ensure the patient was safe.
- Managers had not ensured all ligatures on Cleves Lodge had been included on the ligature risk assessment. We found ligature points in three bedrooms. Ligature points are places to which patient's intent on self-harm might tie something to strangle themselves. Staff did not always adhere to the infection control policy regarding separating clinical waste from general laundry.
- There were insufficient numbers of substantive staff which resulted in the provider using large numbers of temporary staff. The average vacancy rate for qualified staff across the hospital was 48% the vacancy rate for unqualified staff was 43%.
- Staff did not follow the providers incident reporting policy. We found that one patient had not received their medication on five consecutive occasions. This was not reported at the time, we raised this with the ward manager who assured us that it would be reported immediately.
- Managers did not ensure information to deliver care was available to all relevant staff. Temporary staff had read only access to the electronic patient record, which meant they could not update records.
- Clinical documentation was not always reviewed and clearly recorded. Staff had not reviewed 10 out of 17 (59%) risk assessments inspected within the timescales set out in the providers policy. Staff did not always clearly demonstrate whether patients had received a copy of their care plan.
- Practice did not promote the least restrictive environment. We found a blanket restriction in place at the time of inspection. The minutes of the hospital clinical governance meeting which stated that patients would not be allowed to drink caffeinated products from September 2018.
- There was poor communication and governance structures in place. There was a lack of regular staff meetings taking place. Staff told us there had been no staff meetings for several months due to staff shortages, Staff were not aware of the governance structures in place to support best practice. We found a lack of regular community meetings and poor processes for sharing lessons learned.

However:

- Clinic rooms were visibly clean and had enough space to prepare medications, physical health observations were undertaken in patient bedrooms. Physical health monitoring equipment had been calibrated and staff carried out weekly checks to ensure it was in good working order. Staff checked emergency resuscitation equipment on a daily basis and recorded this appropriately.
- Patients had their own bedroom with an en suite shower room. Patients had personalised their room with pictures and soft furnishings and had access to lockable cupboards in which they could store valuable possessions. Patients were individually risk assessed for their suitability to have a key to their bedroom door.
- The hospital had a range of rooms and equipment to support treatment and care. This included quiet rooms for family visits, activity rooms, therapy rooms and a gym. Patients had access to outside space. Patients could make phone calls in private in their bedroom using their mobile or the ward cordless phone.
- The hospital kitchen provided a wide choice of meals for patients which included catering for specific dietary requirements. Healthy options were available and these were clearly displayed in dining rooms. Snacks and drinks were available 24 hours a day. Staff encouraged patients to make them for themselves wherever possible.
- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and

Summary of findings

patients during the inspection and saw that staff were responsive to patient's needs and were respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients at a level that was appropriate to individual needs.

- We spoke with eight carers of people staying at Burton Park, six of which spoke highly of the care their relative received. Carers told us they were generally involved in their relative's care planning reviews and received regular updates to any changes in their care plans, where the patient had consented to their information being shared.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Managers had not ensured all ligatures on Cleves Lodge had been included on the ligature risk assessment. We found ligature points in three bedrooms. Ligature points are places to which patient's intent on self-harm might tie something to strangle themselves. Staff did not always adhere to the infection control policy regarding separating clinical waste from general laundry.
- Staff had not reviewed 10 out of 17 (59%) risk assessments within the timescales set out in the providers policy.
- Practice did not promote the least restrictive environment. We found blanket restrictions in place at the time of inspection. The minutes of the hospital clinical governance meeting which stated that patients would not be allowed to drink caffeinated products from September 2018.
- Staff did not follow the provider medicines management policy. We found three tubes of topical creams in the fridge on Warwick Lodge which had been opened but did not have a label stating which patient was using the cream.
- The average vacancy rate for qualified staff across the hospital was 48% the vacancy rate for unqualified staff was 43%, this resulted in managers using large numbers of temporary staff.
- Staff did not follow the providers incident reporting policy. We found that one patient had not received their medication of five consecutive occasions. This was not reported at the time, we raised this with the ward manager who assured us that it would be reported immediately.
- Managers did not ensure information to deliver care was available to all relevant staff. Temporary staff had read only access to the electronic patient record, which meant they could not update records.
- One patient had been admitted to the hospital on a day when no medical cover was available. The patient did not have their prescription for medication written up until the following day. This meant they had missed five doses of their regular medication, one of which was an anti- epilepsy drug.
- We saw minutes of the providers clinical governance meetings, which showed that incidents were discussed and learning

Summary of findings

identified. Managers told us that they provided governance folders for wards and departments to share this information with staff. However; 20 of the staff we spoke with said they had not seen the governance folders.

However:

- Wards complied with the Department of Health's eliminating mixed sex accommodation guidance, which meant that the privacy and dignity of patients was upheld.
- Clinic rooms were visibly clean and had enough space to prepare medications, physical health observations were undertaken in patient bedrooms for privacy. Physical health monitoring equipment had been calibrated and staff carried out weekly checks to ensure it was in good working order. Staff checked emergency resuscitation equipment on a daily basis and recorded this appropriately.
- Ward managers were able to adjust staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to risks. We reviewed the staffing rota which showed there was sufficient staff to meet the patients' clinical need, however; a high proportion of these were bank or agency staff.
- A qualified nurse was often in the communal areas of the wards, and a support worker was present in the communal areas at all times.

Are services effective?

Good

We rated effective as good because:

- Staff supported patients to access physical healthcare including weekly surgeries at the hospital by the local GP and the hospital physical healthcare lead. Staff escorted patients to attend the general hospital when required.
- Staff ensured that patient's nutrition and hydration needs were assessed and met. The hospital catering staff provided meals tailored to patients' individual needs and preferences.
- Physical healthcare plans were comprehensive with a focus on healthy living. They included identification of high doses of anti-psychotic medication prescribed by the doctor, where ongoing monitoring of physical health was required.
- There was evidence in care records of effective working relationships with teams outside of the hospital for example when patients moved to other care providers and when patients went on leave to other areas of the country or abroad.

Summary of findings

- Staff showed awareness of Mental Health Act principles and knew where to seek further advice. The Mental Health Act administrator carried out audits of Mental Health Act papers to ensure detentions remained legal.
- We reviewed 17 care records which showed that patients had a regular review of their care plan in the transdisciplinary team meetings.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs and were respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients at a level that was appropriate to individual needs.
- Patients told us that staff were supporting them to attend college and to attend gym sessions.
- We spoke with eight carers of people staying at Burton Park, who all spoke highly of the care their relative received.
- Staff demonstrated a good understanding of the individual needs of the diverse patient group. There was evidence of patient involvement in their care planning and risk assessment. Staff supported patients to attend their fortnightly transdisciplinary meetings.
- Managers held “your say” forums to obtain feedback from patients which was used to make improvements to services.
- There were posters displayed on both wards advising patients how to access advocacy services. The advocate visited the wards regularly to talk with patients.
- Carers told us they were involved in their relative’s care planning reviews and received regular updates to any changes in their care plans, where the patient had consented to their information being shared.

However:

- We reviewed 17 care records, staff had not recorded in 10 records if the patient had been offed a copy of their care plan.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- Staff did not routinely move patients between wards during admission unless justified on clinical grounds or in the interest of the patient.
- In the six months prior to inspection there had been no delayed discharges from the hospital.
- The hospital a range of rooms and equipment to support treatment and care. This included quiet rooms for family visits, activity rooms, therapy rooms and a gym. Patients had access to outside space. Patients could make phone calls in private in their bedroom using their mobile or the ward cordless phone.
- Snacks and some drinks were available 24 hours a day. Staff encouraged patients to make them for themselves wherever possible.
- Patients had access to interpreters and signers. Staff arranged for interpreters to attend clinical meetings where appropriate.
- The hospital kitchen provided a wide choice of meals for patients including catering for specific dietary requirements. Healthy options were available and these were clearly displayed in dining rooms.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- We received mixed feedback from staff regarding the visibility of leaders in the service. Some staff reported that leaders were visible and approachable, whereas others said they never saw managers on the wards.
- Whilst we saw that the team working on the wards was good. It was evident through discussion with staff that there was a disconnect between senior managers and the clinical ward staff, and this impacted on the wards team's morale. Staff reported that the senior team appeared to be disjointed and not respectful of each other's profession backgrounds.
- There was a lack of regular staff meetings taking place. Staff told us there had been no staff meetings for several months due to staff shortages, which meant they had not discussed outcomes of investigations, action plans or changes to practice as a result.

Summary of findings

- Managers had not ensured staff complied with the provider medicines management policy, and did not have effective systems and process in place to identify non-compliance. We found three tubes of topical creams which were open but not labelled with the patients' name.
- Clinical information required to deliver care was not available to all relevant staff. For example temporary staff had read only access to the electronic patient record, which meant they could not update records.
- There was a lack of regular patient community meetings were taking place. Staff said they had not held community meetings for several months due to staffing issues.
- Senior managers did not share lessons learned effectively. They told us that they provided governance folders for wards and departments to share learning form incidents with staff. However; 20 of the staff we spoke with said they had not seen the governance folders.
- Managers did not ensure there was adequate medical cover to prescribe essential medication when a patient was admitted to Burton Park.

However:

- The provider used key performance indicators and outcome measures. The measures were in accessible format and used by managers to oversee performance including training, sickness, supervision and appraisal rates.
- Managers ensured that the team objectives reflected organisational vision and values.
- Managers described how they were working to deliver high quality care within the budgets available and could adjust staffing levels when required.

Summary of findings

Information about the service

Burton Park is an independent hospital owned by the Priory Group. This location provides assessment, treatment and neurobehavioral rehabilitation for people with an acquired brain injury (including traumatic brain injury and stroke) and progressive neurological conditions who are over 18 years of age.

Burton Park comprises:

Warwick Lodge is designed specifically for individuals with Huntington's disease and progressive neurological conditions where movement disorders and complex physical health needs are present. It caters for individuals who require support and rehabilitation to stabilise their condition before they are able to transition back to community services, however, it will also cater for patients that require long term hospital care, providing care throughout all stages of illness including end of life care for patients who require enhanced support due to the nature and degree of their condition and level of risk and behaviour that challenges.

Cleves Lodge is a 26 bedded unit which is split into 2 wards, catering for slow stream rehabilitation, as well as progressive neurological conditions.

Dalby Unit is a female only unit with nine beds. Dalby Unit provides for people with acquired brain injury or progressive neurological conditions who have greater independence and can spend a proportion of the day engaged in meaningful activity without direct/frequent staff support.

Burton Park has been registered with CQC since 8 December 2014. Burton Park is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

There have been two inspections carried out at Burton Park in October 2015 and June 2017.

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

Mental Health Act T3 (consent to treatment) forms were not always accurate with regard to the medicine prescribed and administered to the patient on the prescription chart.

Medicine refrigerator temperatures were outside of the normal range in one of the fridges.

Physical health monitoring of patients was not always completed following rapid tranquilisation medication.

Some ward areas were dirty and posed an infection control risk.

Ligature cutters were not easily available for staff in an emergency.

The environment on Warwick Lodge was such that patients in bariatric wheelchairs could not access all areas of the ward. We found these issues had been addressed on this inspection.

Our inspection team

Team leader: Michelle Edwards, CQC inspector

The team that inspected the service comprised two additional CQC inspectors, one assistant inspector and one specialist advisor.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 13 patients who were using the service;
- spoke with eight carers of patients who were using the service;
- spoke with the registered manager and the managers, or deputy managers for each of the wards;
- spoke with 29 other staff members; including doctors, nurses, occupational therapist, psychologist, social workers and administrators;
- attended two morning management meetings;
- observed three therapy interventions;
- looked at 17 care and treatment records of patients;
- carried out a specific check of the medication management including reviews of 34 prescription charts;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- We spoke with 13 patients and eight carers.
- Patients said they felt safe in the hospital, and they told us staff were kind.
- Patients told us the variety and quality of food was good, they could personalise their bedroom space and staff understood their needs.
- Four patients we spoke with said they understood their rights under the Mental Health Act, and staff informed them of their rights in a way they could understand.
- Six carers told us they were very happy with the care their family member was receiving at the hospital and felt that communication between them and the hospital was good.
- One carer told us that staff did not always introduce themselves when they answered the phone.
- One carer told us that complaints were not always followed up in writing.
- Four patients stated that the range of planned activities was limited and not always challenging enough for them. Four patients told us they did not understand how activities on the ward helped them.

Good practice

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that incidents are reported and investigated in a timely way.
- The provider must ensure that they are complaint with their ligature risk assessment policy and all ligatures are included on the risk assessment.
- The provider must ensure that blanket restrictions are applied only when clinically justified and reviewed as per the Mental Health Act Code of Practice.
- The provider must ensure adequate medical cover to prescribe medication on admission and at any time thereafter.

Summary of findings

- The provider must ensure adequate numbers of substantive staff with the knowledge and skills required for the clinical service provided.
- The provider must ensure that all staff have easy access to all clinical records including temporary being able to upload clinical information in a timely way.

Action the provider SHOULD take to improve

- The provider should ensure there are regular ward meetings and patient community meetings.
- The provider should ensure adherence with their medicines management policy, that open topical creams are labelled with the patient's name.
- The provider should ensure that staff comply with the providers infection control policy.
- The provider should ensure risk assessments are updated as per the providers own policy.

Partnerships in Care Limited

Burton Park

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Burton Park	Burton Park

Mental Health Act responsibilities

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

- At the time of the inspection, there were 36 patients at the hospital, and 24 of those patients were detained under the Mental Health Act 1983.
- Staff demonstrated understanding of the Mental Health Act principles and knew where to seek further advice. The Mental Health Act administrator carried out audits of Mental Health Act papers to ensure detentions remained legal.
- Staff completed contingency plans prior to patients utilising escorted section 17 leave. This meant that they knew what to do if something untoward happened.
- Staff attached T2 and T3 consent to treatment forms to medication cards where necessary.
- Staff explained patients' rights in a way they could understand, in accordance with section 132 of the Mental Health Act. Patients had access to independent advocacy services, and staff encouraged them to seek support from this service.
- The hospital displayed information on access to independent Mental Health Act advocates on the wards.
- Data provided at the time of inspection showed 85% of staff had completed Mental Health Act training. A Mental Health Act administrator was available on site to offer support to staff.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Data for the period February 2018 to August 2018 showed 87% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguarding training, and this training was mandatory.
- Staff were aware of their responsibilities under the Mental Capacity Act and Deprivation of Liberty

Safeguarding and understood how the guiding principles applied to their work roles; they knew where to get advice from regarding Mental Capacity Act and could refer to the policy if needed.

- During the period February 2018 to August 2018, Burton Park made 12 Deprivation of Liberty Safeguarding applications.
- Staff completed capacity assessments where required, which were decision specific and filed in patients care notes. There were no best interest meeting records and staff told us they could not recall when the last best interest meeting had taken place.
- Audits were in place to monitor the providers' compliance with Mental Capacity Act.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The wards had some blind spots impacting on lines of sight for staff to observe patients. The provider had installed mirrors to mitigate the risks and positioned staff in corridor areas to promote observation of patients.
- Managers had not ensured all ligatures on Cleves Lodge had been included on the ligature risk assessment. We found ligature points in three bedrooms. Ligatures points are places to which patient's intent on self-harm might tie something to self-ligate themselves. Staff knew where to locate ligature cutters on each ward.
- Wards complied with the Department of Health's eliminating mixed sex accommodation guidance, which meant that the privacy and dignity of patients was upheld.
- Staff carried personal alarms or radios, which they used to summon help in an emergency. Patients had access to a nurse call system in their bedrooms and clinical areas.
- Wards were generally clean, well maintained and had good quality furnishings, however we saw high level dust on Cleves Lodge. Staff told us that there were plans of an upgrade to the environment and furnishing on Cleves ward. The infection control policy was in date and staff demonstrated knowledge of infection control principles. However; housekeeping staff told us that staff did not always adhere to the policy regarding separating clinical waste from general laundry. Cleaning records were available and up to date.
- There were no seclusion rooms at the hospital, staff told us they used de-escalation strategies in quiet areas of the ward.
- Clinic rooms were visibly clean and had enough space to prepare medications, physical health observations were undertaken in patient bedrooms for privacy. Physical health monitoring equipment had been calibrated and staff carried out weekly checks to ensure it was in good working order. Staff checked emergency resuscitation equipment on a daily basis and recorded this appropriately.

Safe staffing

- The whole time equivalent (wte) of qualified staff on Cleves Lodge was 11.0 with 6.0 (54%) vacant posts at the time of the inspection. The wte of unqualified staff was 81 with 43 (53%) vacant posts at the time of the inspection.
- The whole time equivalent (wte) of qualified staff on Warwick Lodge was 4.0 with 2.0 (50%) vacant posts at the time of the inspection. The wte of unqualified staff was 8.0 with no vacant posts at the time of the inspection.
- The whole time equivalent (wte) of qualified staff on Dalby Unit was 3.6 with 1.4 (39%) vacant posts at the time of the inspection. The wte of unqualified staff was 12.0 with 4.0 (33%) vacant posts at the time of the inspection.
- The sickness rate across the service was 12%. Managers told us this was due to a mixture of staff on long term and short-term sickness.
- Between May 2018 and August 2018, bank or agency staff had filled 2401 shifts to cover enhanced observation levels, vacancies or sickness. Wherever possible agency staff were booked for extended periods of time and were offered training and supervision to ensure consistency of care for patients.
- Ward managers were able to adjust staffing levels to meet the changing needs of patients requiring high levels of monitoring linked to risks. We reviewed the staffing rota which showed there was sufficient staff to meet the patients' clinical need, however a high proportion of these were bank or agency staff.
- A qualified nurse was often in the communal areas of the wards, and a support worker was present in the communal areas at all times.
- Staff reported that escorted leave was occasionally cancelled or rearranged due to staff shortages. The staffing rotas showed there was the appropriate number of qualified nursing staff on each shift.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- There was adequate medical cover both during the day and at night with both consultant psychiatrists covering for each other's absence. However; managers had arranged for a patient to be admitted on a day when there was no medical cover available on site This meant a patient did not have their prescription written in a timely way.
- Staff were up to date with mandatory training with the average mandatory training rate being 93%. No elements of training fell below 75%.

Assessing and managing risk to patients and staff

- We reviewed 17 care records. Each patient had an individualised risk assessment completed on admission. Staff used the providers risk assessment tool, however 10 out of the 17 (59%) risk assessments inspected were not reviewed within the timescales set out in the providers policy.
- Staff described how they identified and dealt with risk issues such as swallowing problems, pressure ulcers and risk of falling. We saw these were then documented within the clinical record.
- There were policies and procedures for use of observation (including minimising risk from ligature points). Staff carried out enhanced observations of patients and kept up to date records showing interventions used to engage the patient.
- The provider did not use seclusion at the hospital.
- Practice did not promote the least restrictive environment. We found a blanket restriction in place at the time of inspection. The minutes of the hospital clinical governance meeting which stated that patients would not be allowed to drink caffeinated products from September 2018.
- In the last six months staff had used restraint 103 times. The highest number of restraints was on Cleves ward which reported 94 restraints. Managers told us the majority of restraints were at a very low level for example guiding patients by the arm. There were no incidents of prone (face down) restraints reported. Staff described how they would attempt de-escalation techniques before using restraint.
- We looked at five incidents where rapid tranquilisation had been used, there was evidence that staff had carried out physical health monitoring in all five cases.

Safeguarding

- Staff gave examples of how they would identify and make a safeguarding referral. Data provided at the time of inspection showed 96% of staff had received safeguarding adult and children training. We saw how staff worked in partnership with other agencies to safeguard people. There was a visiting policy to include children, and a family room was available which was child friendly.

Staff access to essential information

- Managers did not ensure information to deliver care was available to all relevant staff. Temporary staff had read only access to the electronic patient record, which meant they could not update records.

Medicines management

- Staff did not follow the provider medicines management policy, we found three tubes of topical creams in the fridge on Warwick Lodge which had been opened but did not have a label stating which patient was using the cream.
- The provider used a community pharmacy service which undertook audits on a weekly basis issues identified in the audit were discussed in the monthly governance meeting.

Track record on safety

- Managers did not ensure information to deliver care was available to all relevant staff. Temporary staff had read only access to the electronic patient record, which meant they could not update records.

Reporting incidents and learning from when things go wrong

- Staff we spoke with described how they would report incidents, escalating to their line manager or the safeguarding lead and if necessary recording on the electronic incident reporting system. However, staff had failed to report an incident when a patient did not receive their medication, one of which was an anti-epilepsy drug.
- Staff described understanding the Duty of Candour; how they were open and transparent and explained to patients when things went wrong.
- Staff told us they were offered debriefs and felt supported after serious incidents.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Managers held daily morning meetings to discuss any serious incidents from overnight or the previous day.
- Senior managers discussed serious incidents at the clinical governance meetings and documented learning from the investigations across the site in governance folders held on each ward and department. However; staff we spoke with said they had not seen the governance folders.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed 17 care records. Staff completed comprehensive assessments for all patients at the point of admission. Care plans were all in date, personalised, holistic, and recovery orientated.
- Physical healthcare plans were comprehensive with a focus on healthy living. They included identification of high doses of anti-psychotic medication prescribed by the doctor, where ongoing monitoring of physical health was required.

Best practice in treatment and care

- The team provided National Institute for Health and Care Excellence recommended psychological therapies, they also used the Independent Neurorehabilitation Providers Alliance guidance, to provide the most up to date evidence based information.
- Staff supported patients to access physical healthcare including weekly surgeries at the hospital by the local GP and the hospital physical healthcare lead. Staff supported patients to attend the general hospital when required.
- Staff ensured that patient's nutrition and hydration needs were assessed and met. The hospital catering staff provided meals tailored to patients' individual needs and preferences.
- Staff used a range of recognised rating scales to assess and record the severity and outcomes of neurological conditions. These included the functional independence measure and functional assessment measure.
- Staff carried out a range of audits including, physical health monitoring, care plan audits, medication management, and infection control audits.

Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including nurses, doctors, clinical psychologists, occupational therapists and technical instructors, social workers and speech and language therapists.
- There was an induction and mandatory training program for all new staff including new bank and agency staff, and senior managers monitored this. Staff we spoke with said the programme was very comprehensive. Healthcare assistants used their probation period to work towards their care certificate. The care certificate aims to equip staff with the knowledge and skills which they need to provide safe compassionate care.
- We reviewed staff recruitment files for nine staff. Staff had completed disclosure baring service checks (DBS) and these checks were repeated on a three-yearly basis. Membership and revalidation to professional bodies had been complied with where relevant.
- Data provided at the time of inspection showed 95% of staff were up to date with supervision and 97% of staff had had an annual appraisal.
- Managers said they had support both locally and centrally to manage poor performance promptly.

Multi-disciplinary and inter-agency team work

- The provider held regular transdisciplinary meetings. We reviewed 17 care records which showed that patients had a regular review of their care plan in the meeting. The transdisciplinary model is one where specialist professionals inform the formulation and care plan of patients but the interventions may be carried out by all members of the transdisciplinary team.
- There was evidence of effective handovers on each of the three wards. Handovers were recorded on handover sheets which included any changes to the patients' risk or physical condition.
- There was evidence in care records of effective working relationships with teams outside of the hospital for example when patients moved to other care providers and when patients went on leave to other areas of the country or abroad.

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

- At the time of the inspection, there were 36 patients at the hospital, and 24 of those patients were detained under the Mental Health Act 1983.
- Staff showed awareness of Mental Health Act principles and knew where to seek further advice. The Mental Health Act administrator carried out audits of Mental Health Act papers to ensure detentions remained legal.
- Staff completed contingency plans prior to patients utilising escorted section 17 leave. This meant that they knew what to do if something untoward happened.
- Staff attached T2 and T3 consent to treatment forms to medication cards where necessary.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff explained patients' rights in a way they could understand, in accordance with section 132 of the Mental Health Act. Patients had access to independent advocacy services, and staff encouraged them to seek support from this service.
- The hospital displayed information on access to independent Mental Health Act advocates on the wards.
- Data provided at the time of inspection showed 85% of staff had completed Mental Health Act training. A Mental Health Act administrator was available on site to offer support to staff.

Good practice in applying the Mental Capacity Act

- Data for the period February 2018 to August 2018 showed 87% of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguarding training, and this training was mandatory.
- Staff were aware of their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguarding and understood how the guiding principles applied to their work roles; they knew where to get advice from regarding Mental Capacity Act and could refer to the policy if needed.
- During the period February 2018 to August 2018, Burton Park made 12 Deprivation of Liberty Safeguarding applications.
- Staff completed capacity assessments where required, which were decision specific and filed in patients care notes. There were no best interest meeting records and staff told us they could not recall when the last best interest meeting had taken place.
- Audits were in place to monitor the providers' compliance with Mental Capacity Act.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff treated patients with kindness, compassion and respect. We observed interactions between staff and patients during the inspection and saw that staff were responsive to patient's needs and were respectful. Staff treated patients with dignity and remained interested when engaging patients in meaningful activities. Staff interacted with patients at a level that was appropriate to individual needs.
- Patients told us that staff were supporting them to attend college and to attend gym sessions.
- We spoke with eight carers of people staying at Burton Park, who all spoke highly of the care their relative received.
- Staff demonstrated a good understanding of the individual needs of the diverse patient group.

The involvement of people in the care that they receive

- Patients were orientated to the wards on admission to the hospital and informed of the service they could expect to receive.
- There was evidence of patient involvement in their care planning and risk assessment. However, staff did not always clearly demonstrate whether patients had received a copy of their care plan. Staff supported patients to attend their fortnightly transdisciplinary meetings.
- Managers held “your say” forums to obtain feedback from patients which was used to make improvements to services, however, patients said ward community meetings were rarely held.
- There were posters displayed on both wards advising patients how to access advocacy services. The advocate visited the wards regularly to talk with patients.
- Carers told us they were involved in their relative’s care planning reviews and received regular updates to any changes in their care plans, where the patient had consented to their information being shared.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Burton Park reported their average bed occupancy for the period 1 February 2018 to 31 July 2018 at 77% for Dalby ward and 88% for Cleves (Warwick ward was closed for refurbishment during this time perimeter). The average length of stay across the site was 498 days.
- Staff did not routinely move patients between wards during admission unless justified on clinical grounds or in the interest of the patient.
- The provider was responsive to referrals usually being able to arrange assessment within a week of receipt of the referral, however we saw that one patient had been admitted to the hospital on a day when there was no access to the consultant psychiatrist. This meant the prescribing of medication for this patient was not completed in a timely way.
- In the six months prior to inspection there had been no delayed discharges from the hospital.
- Staff described how they had supported patients to transfer to other facilities and hospitals.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedroom with an en suite shower room. We saw that patients had personalised their room with pictures and soft furnishings.
- Patients had access to lockable cupboards in which they could store valuable possessions. Patients were individually risk assessed for their suitability to have a key to their bedroom door.
- The hospital had a range of rooms and equipment to support treatment and care. This included quiet rooms for family visits, activity rooms, therapy rooms and a gym. Patients had access to outside space. Patients could make phone calls in private in their bedroom using their mobile or the ward cordless phone.
- Snacks and some drinks were available 24 hours a day. Staff encouraged patients to make them for themselves wherever possible.

Patients' engagement with the wider community

- Staff supported patients to access services in the wider community, one patient told us they were planning to undertake a college course.
- Patients were encouraged to maintain contact with family and carers, one patient told us they were going abroad to visit family and one carer told us they were spending Christmas day at the hospital with their family.

Meeting the needs of all people who use the service

- The service was accessible for people requiring disabled access.
- Accessible information on treatments, medication and how to complain were displayed throughout the hospital. All information was available in easy read format to enhance the patients understanding.
- Patients had access to interpreters and signers. Staff arranged for interpreters to attend clinical meetings where appropriate.
- The hospital kitchen provided a wide choice of meals for patients. We saw evidence this choice included catering for specific dietary requirements. Healthy options were available and these were clearly displayed in dining rooms.
- Spiritual care and chaplaincy was provided when requested and a multi faith room was available for patients and their families to use.

Listening to and learning from concerns and complaints

- In the 12 months preceding this inspection the hospital received one complaint. The complaint centred around a family member's understanding of terminology used in a clinical meeting. It was not upheld.
- Patients and carers told us they knew how to make a complaint, and staff told us how they handled complaints in line with hospital policy.
- Staff told us that they received feedback from investigations of complaints and acted on the findings, however one carer told us complaints were not always followed up in writing. We looked at one historical complaint which had been thoroughly investigated and responded to within agreed timescales.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Leadership

- Leaders we spoke with had the skills, knowledge and experience to perform their roles. They were passionate about their service and described how they were striving to continually improve care for patients.
- We received mixed feedback from staff regarding the visibility of leaders in the service. Some staff reported that leaders were visible and approachable, whereas others said they never saw them on the wards.
- Staff told us that leadership opportunities were available.

Vision and strategy

- Not all staff could describe the providers vision and values. Some staff knew they could find information about the values on the intranet. Staff did not feel involved in creating and developing the vision and values.
- Managers ensured that the team objectives reflected organisational vision and values.
- Managers described how they were working to deliver high quality care within the budgets available and could adjust staffing levels when required.

Culture

- Most staff felt respected, valued and supported. A minority of staff told us that the provider had made a lot of changes without consultation.
- Whilst we saw that the team working on the wards was good. It was evident through discussion with staff that there was a disconnect between senior managers and the clinical ward staff, and this impacted on the wards team's morale. Staff reported that the senior team appeared to be disjointed and not respectful of each other's profession backgrounds.
- Staff told us they knew how to use the whistleblowing process and felt able to raise concerns without fear of victimisation. There were no reported cases of bullying or harassment.
- Managers dealt with poor staff performance when needed.
- Managers celebrated good practice by holding staff member of the month awards.
- Sickness and absence rates amongst permanent staff across the service was 12%. Managers were supporting staff back to work by offering phased returns.

Governance

- Oversight of governance was not robust. We found poor practice around medicines management, infection control, incident reporting and risk assessments not being updated. Managers had not identified or addressed these issues.
- Managers ensured that staff were up to date with mandatory training.
- Managers had not ensured staff complied with the provider medicines management policy, and did not have effective systems and process in place to identify non-compliance. We found three tubes of topical creams which were open but not labelled with the patients' name.
- Managers ensured staff were supervised and appraised regularly, the compliance rate across the site was 89%.
- Managers ensured that staff maximised their shift-time on direct care activities as opposed to admin tasks. However; there was a high use of bank and agency staff due to sickness and vacancy levels. Whist the service had an ongoing recruitment plan, vacancy rates remained high.
- Senior managers did not share lessons learned effectively. They told us that they provided governance folders for wards and departments to share lessons learnt form incidents with staff. However; 20 of the staff we spoke with said they had not seen the governance folders.
- Managers had not ensured that regular staff meetings were taking place. Staff told us there had been no ward meetings for several months due to staff shortages, which meant they had not discussed how outcomes of investigations had been implemented.
- Ward managers told us they had sufficient authority to do their job, good administration support and had the ability to submit items to the organisational risk register

Management of risk, issues and performance

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff were able to access the risk register and could escalate concerns when required.
- Managers did not ensure that staff followed the providers incident reporting policy. We found that one patient had not received their medication of five consecutive occasions. This was not reported at the time, we raised this with the ward manager who assured us that it would be reported immediately.
- The service had business continuity plans to manage emergency situations, for example, adverse weather events.
- Managers did not ensure there was adequate medical cover to prescribe essential medication when a patient was admitted to Burton Park.

Information management

- The provider used systems to collect data from wards that were not over burdensome on staff. Staff had access to the equipment and technology they needed to do their work.
- Managers did not ensure information to deliver care was available to all relevant staff. Temporary staff had read only access to the electronic patient record, which meant they could not update records.
- The provider used key performance indicators and outcome measures. The measures were in an accessible format and used by managers to oversee performance including training, sickness, supervision and appraisal rates.
- Staff made notifications to external bodies as required.

Engagement

- Staff had access to information about the work of the provider through the intranet, emails and newsletters.
- Managers held “your say” forums to obtain feedback from patients which was used to make improvements to services.
- Staff said they had not had the opportunity to contribute to the development of the service.
- Senior leaders engaged with external stakeholders, for example NHS England and Clinical Commissioning Groups.

Learning, continuous improvement and innovation

- Burton Park is a member of the Independent Neurorehabilitation Providers Alliance (INPA) and is a recipient of the 2017 rapid assessment, interface and discharge (RAID) award for excellence in working with challenging behaviour by the Association of Psychological Therapies.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Blanket restrictions were in place, patients we not allowed caffeinated drinks. This was a breach of regulation 9

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Not all ligatures had been identified and included on the ligature risk assessment on Cleves ward. Managers had failed to ensure medical staff were on site to admit a patient to the hospital. This was a breach of regulation 12

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 Systems were not in place to ensure incidents were reported in a timely way. Temporary staff were not able to access the electronic system to record clinical information. The provider had not ensured adequate numbers of substantive staff. This was a breach of regulation 17