We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

## The Dene

Gatehouse Lane, Goddards Green, Hassocks, BN6 9LE  
Tel: 01444231000

Date of Inspection: 20 November 2012  
Date of Publication: December 2012

We inspected the following standards as part of a routine inspection. This is what we found:

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<td>Partnerships in Care Limited</td>
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<tr>
<td>Registered Manager</td>
<td>Ms. Sarah Shepherd</td>
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<tr>
<td><strong>Overview of the service</strong></td>
<td>The Dene is a modern purpose-built hospital providing specialised medium and low secure services and care for people with mental health needs, and/or mild learning disabilities, and/or problems with substance misuse. The services currently comprise two female medium secure wards, two female low secure wards and two male acute admission wards. The provider is Partnerships in Care Limited, for whom the nominated individual is Steven Woolgar. The registered manager is Sarah Shepherd.</td>
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<td><strong>Type of service</strong></td>
<td>Hospital services for people with mental health needs, learning disabilities and problems with substance misuse</td>
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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 20 November 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who represent the interests of people who use services, talked with people who use the service and talked with staff.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

It is to be noted that on the day of our inspection we were accompanied by a Mental Health Act Commissioner (MHAC). They visited one ward (Amy Johnson) to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. Their findings on this ward, including in relation to privacy and dignity and activities differed from our experience throughout the rest of the hospital. The MHAC identified issues which were specific to Amy Johnson Ward and these have been recorded and addressed under their own monitoring process.

We found that individual care plans included a section which incorporated the patient’s view and experience of various aspects of service provision.

We found that the service did not protect patients against the risks associated with the unsafe use and management of medication by means of appropriate arrangements for the obtaining, recording, using, safe keeping and safe administration of medicines.

The registered manager told us that staffing levels throughout The Dene were now closely monitored to ensure that they reflected the assessed treatment and support needs of patients.

We spoke to a Senior Support Worker who had worked at The Dene for many years who stated, "I feel supported by my managers, I have no issues and have regular supervisions."
If I do need to raise an issue I will speak to my managers - or other staff on other wards."

You can see our judgements on the front page of this report.

**What we have told the provider to do**

We have asked the provider to send us a report by 29 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

**More information about the provider**

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Respecting and involving people who use services ✔ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People’s privacy, dignity and independence were respected. People’s views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who use the service understood the care and treatment choices available to them. People expressed their views and were involved in making decisions about their care and treatment.

We were informed by ward managers (including on Helen Keller Ward and Wendy Orr Ward that patients were supported, enabled and encouraged to express their views and make or participate in making decisions relating to their care and treatment. This included flexible care pathways and The Care Programme Approach (CPA)). We found that systems for consultation, interaction and communication were effective and individuals generally had their privacy and dignity upheld. During our visit patients were observed being spoken with and supported in a sensitive, respectful and professional manner.

The registered manager also told us that in addition to being involved in their individual care and treatment, patients were actively encouraged to take part in other decision making processes within the hospital. An example of this was that patients were routinely involved in the recruitment and selection process for new staff at The Dene.

On Amy Johnson Ward, we found improvement on the evidencing of the participation principle throughout a range of documents. For example, on the notes, that reviews of care plans and risk assessments were taking place and acknowledged patient’s diverse needs. On being shown around the ward, we found that the patients had their own rooms en suite. However it was noticeable that the observation windows were locked open which meant that patients had no privacy when in their own rooms. The expert by experience commented: "It would not have been a problem if staff had closed these windows and only opened them when doing their observations".

On Michael Shepherd Ward we found that the kitchen was locked. Staff told us that, following risk assessments, some people had access to it, but most did not. There was no separate area for patients to make drinks. However, people told us they could ask for
drinks whenever they wanted, and we observed that staff were regularly making drinks for people throughout the day.

We were told that 'community meetings' were held each morning and were said by staff and patients to provide an opportunity for people to raise and discuss any issues or concerns that they might have. On Helen Keller ward this included an extended community meeting each week when patients were actively encouraged and enabled to participate.

It was noted in the minutes of a recent patients council meeting that the frequency of community meetings was being affected by staff shortages. This was discussed with ward managers and patents, who confirmed that the situation had improved and community meetings were now taking place most mornings.

Asked about how privacy and dignity was addressed on the wards, staff advised us that all people accommodated on the wards had their own bedroom with en-suite facilities. There were also quiet room and one-to-one sessions for people who wished to discuss issues of a sensitive nature.
Consent to care and treatment

Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We were informed by the registered manager that The Dene had in place a robust admission policy and procedure. Prior to an individual moving in, a comprehensive and detailed admission assessment is undertaken that provides a clear understanding of their 'strengths, needs and risks'.

It was noted on Amy Johnson Ward that all detention documents scrutinised appeared lawful and in good order with Approved Mental Health Practitioner (AMHP) reports available.

However the registered manager told us that the situation regarding acute admission was very different. People admitted to these wards (Elizabeth Anderson Ward and Michael Shepherd Ward) would often have no 'history' and apart from their diagnosis and 'current presentation' there may be very little additional information available.

This was evident during our visit to Michael Shepherd Ward, where it was found that there was limited information on some admission sheets and occasionally people had been admitted without the necessary section papers.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

On Amy Johnson Ward we found some improvement of assessment of capacity to consent on admission by use of the providers four-point test for capacity form, detailed on the reverse of the T2/T3 certificates, but this was found to be not always consistent or on an ongoing basis.

Consent forms, including T2, T3 and CO3 were found to be in place on Wendy Orr Ward and Helen Keller Ward.
Care and welfare of people who use services

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Care plans were examined (Helen Keller Ward and Wendy Orr Wards) which were comprehensive and updated consistently. Each plan contained Initial Assessment records, medical observations, secure ratings, Star Recovery care plans, and very detailed notes of behaviours and medications.

We found that individual care plans included a section which incorporated the patient's view and experience of various aspects of service provision, including:- circumstances leading to their admission and what progress they think that they have made since the last CPA meeting (Care Programme Approach)

On Wendy Orr Ward we asked a patient if they had a copy of their care plan. They said that they might have a copy somewhere, but that they did write the plan together with the nurse.

On Michael Shepherd Ward we found that one of the care plans contained detailed records of a person who had been agitated and spent period of time in seclusion. This appeared detailed, showed that attempts had been made to de-escalate the situation prior to the person being secluded, and that most of the specific seclusion documentation had been completed as required. This included reviews by nursing and medical staff.

We were informed that among the treatment programmes available at the Dene was Dialectical Behaviour Therapy (DBT) which is a psychological therapy for people with borderline personality disorder (BPD), especially those with self-harming behaviour or suicidal thoughts.

The Recovery Star Care planning tool allows mental health services to work in a visual way with service users and their families, carers and supporters to support and measure change, to identify the support and treatment needed and to help prioritise treatment goals.
Although we were told by ward managers that commissioners would not routinely fund activities, we found a diverse range of group activities available to patients throughout the hospital.

We found that an occupational therapy (OT) organised activity planner had been developed for several wards including Helen Keller Ward and Amy Johnson Ward. Activities included: rambling; creative group; gardening; card making; gym; self esteem; needle work; music group; swimming; substance misuse; walks; puppets group; let's dance; dog walking; photography and cinema.

We spoke with two occupational therapists who confirmed that activities were arranged, as far as practicable, to reflect patients' identified interests. However, they added that although patients were supported and encouraged to be involved in the group sessions, some were more enthusiastic than others.

During our inspection we did find inconsistencies on some wards regarding the provision of activities. The Charge Nurse on Michael Shepherd Ward confirmed that there were no activities provided on the acute wards. He said that the funding authority "doesn't pay for 'extras' like OT activities". He said they just wanted medical and nursing care. He said that "people want to go out, they don't want to do activities on the wards". He also said that the original model was that people would only be there for a few days, but in reality people could be there for several weeks.

There was a large activity room on the ward, but staff told us this wasn't often used for activities. There was a large communal area between the two acute wards, which had sofas and a pool table, and the shop. We did not see this in use during our inspection. People told us that they tended to use the room after dinner.

Staff on the ward told us that people used the sports hall (although we didn't see this), took their leave (if they had this) and could play board games and watch television. However, there was no structured programme of activities, and there was no occupational therapist or activity co-ordinator.

One patient told us that he liked playing pool – which usually happened after dinner – and watching television. He said "it can get boring" but he liked sitting in his room listening to music and reading.

The provider may wish to consider the lack of adequate structured activity and therapy programmes on the acute wards.

The section 17 records of four people were viewed. These showed that people had detailed section 17 leave forms, that the leave was recorded, and that the leave had been taken. The informal patients we spoke with said they were able to leave the ward when they wanted. We observed that although staff were busy, facilitating people's leave was seen as a priority and time was spent organising this.
Safeguarding people who use services from abuse  

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. This was supported by updated policies and procedures, relating to safeguarding people at risk, that we were shown. It was also confirmed through discussions with patients and staff throughout the hospital.

One member of staff on Michael Shepherd Ward told us that she thought the relational security approach worked on the ward. They explained that this is about the relationship staff have with patients, and about their understanding of not only that particular patient, but how they might interact with other patients/staff, and other dynamics on the ward. They told us that there was a high turnover of patients so ‘it could be volatile’.

The provider responded appropriately to any allegation of abuse. People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements.

We were told that all permanent and bank staff were trained in managing violence and aggression (MVA), but agency staff weren't always trained. They said that if there were a lot of agency on a particular ward, they would be moved around so that there were MVA trained staff on all the wards. They said that they would be able to deal with incidents if all the staff were on the ward, but the numbers could be depleted when staff were on breaks, or taking people out.

Staff told us that they have radios and alarms. We were told there is an allocated member of staff assigned to the response team.

Staff told us that if a patient was in seclusion or 1-1 they would initially use staff from the ward numbers, but then they would book extra staff.

We looked at the seclusion suite next to Michael Shepherd ward. It had two seclusion rooms with a shared reception area. The reception area contained a sofa that could be used for de-escalation, and a dividing curtain to promote privacy. The seclusion rooms were ligature free, had windows, and behind glass there was a clock, TV and radio. There
was an en-suite shower/toilet. Staff could access this room from outside the suite, so they did not have to enter the seclusion room if people wanted to use the toilet. There were notices on the wall explaining the action staff should take in the event of anaphylactic shock or cardiac arrest. We were told that the emergency equipment was stored on the adjacent Michael Shepherd ward.

One patient we spoke with on Helen Keller Ward told us that they feel safe 'most of the time'. When asked what they would do if they were worried or had a problem, they replied, "I would speak to a member of staff if I had an issue." They also said that there were no physical fights on the ward but sometimes there could be arguments 'when people got agitated'.
Management of medicines

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

The service did not protect patients against the risks associated with the unsafe use and management of medication by means of appropriate arrangements for the obtaining, recording, using, safe keeping and safe administration of medicines.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

To assess the management of medicines we visited two wards at the hospital. We spoke with patients who had been admitted to the hospital and registered nurses.

Nurses told us that they thought pharmacy services provided on the wards were generally good but that there were sometimes delays in obtaining medicines. We noted a number of prescription charts where medicines were not administered to patients because they were not available on the ward. This meant that there were delays in administering prescribed medicines for varying periods of time placing patients at risk. We also noted gaps on prescription charts where we could not determine if medicines prescribed for regular administration had been administered or any reasons why they had not been given. This included a depot psychotropic injection where records indicated it was administered approximately one week late. This meant some medicines may not have been administered as intended by the prescriber. Nurses told us there were systems in place to monitor records and audit the quality of medicine management at the service but we concluded that these were not sufficiently effective.

We observed part of the lunchtime medicine round and found that safe procedures were followed by the nurse on duty. We also found that additional steps had been taken to reduce the risk that patients could hide medicines in their mouth to accumulate and misuse later. However, on one ward we noted there to be a lack of means of identification of patients available to assist in safety when nurses administered their medicines. We also found there to be a lack of written information available to guide staff when administering medicines prescribed to be given when required or as necessary (PRN medicines). A patient using the service told us nursing staff have an inconsistent approach when they felt they needed their medicines that were prescribed in this way. We noted a separate chart used to record the increasing schedule of an antipsychotic medicine for one patient was not completed with dates the medicine was administered. This was unsafe practice which could have led to error.

A registered nurse told us that medicines were checked by a consultant and nurse when
patients are admitted onto the ward. We noted evidence that consultants regularly review psychotropic medicines but the hospital could not provide recorded evidence of the involvement of GPs in reviewing other medicines that were prescribed for patients. Patients we spoke with said they would like more information about medicines when they were first prescribed.

Whilst we were on the wards we noted that medicines were being kept securely. Records of room temperatures were being kept on a daily basis which showed medicines were being kept within the accepted range. However, on one ward, we noted that medicine refrigerator temperatures were frequently lower than the accepted temperature range for the safe storage of medicines. This means medicines stored within the refrigerator may have no longer been suitable for use.

We saw that there were emergency medicines and written procedures available for the treatment of anaphylactic shock. However nurses we spoke with were unclear on how to access other medicine policies and procedures. We were told by senior management that a medicine policy document is available at the hospital for staff to refer to and also that this will shortly be updated.

Nurses told us that there was no provision for patients to manage some or all of their own medicines in any area of the hospital. One senior nurse we spoke with told us some patients may benefit from this as part of their rehabilitation and that the hospital should consider making arrangements for self-medication in some circumstances.
Staffing

| There should be enough members of staff to keep people safe and meet their health and welfare needs |

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<tr>
<td>Met this standard</td>
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Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people’s needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

Concerns were raised at the last inspection regarding inadequate staffing levels on certain wards and the impact that this had on the safety and welfare of patients. There has also been a high level of notifications within the last 12 months, many relating to altercations between patients.

At the start of our inspection we met with the Regional Contracts, IT & Governance Manager and a senior charge nurse who advised us of current staffing levels throughout the hospital.

On Wendy Orr Ward (Female low secure – seven patients) there were five staff during the day and four at night.

On Elizabeth Anderson Ward (Male acute – eight patients) there were three staff on duty day and night.

On Edith Cavell Ward (Female low secure – 16 patients) there were five staff during the day and four at night.

On Michael Shepherd Ward (Male acute admission – 15 patients) there were five staff on duty day and night.

On Helen Keller Ward (Female medium secure - currently 13 patients) ) there were five staff during the day and four at night.

On Amy Johnson Ward (Female medium secure – 11 patients) there were eight staff on duty day and night. It was explained to us that on this ward, following assessments, one patient required 1:1 observation and two other patients received 2:1 observation and support.

The senior charge nurse confirmed that on each shift, on all of the wards, there would be at least one and frequently two qualified nurses on duty.
These numbers were corroborated by staff rotas that we were shown on the wards and also through discussions with ward managers and other staff.

On Helen Keller Ward we spoke with two patients who told us that they were happy with the number of staff on the ward and said that ‘there’s always someone around’.

The ward manager told us that any staff shortages, for whatever reason, would be covered by regular bank staff, who were familiar with the patients and the routines on the ward. This was supported by a health care worker we spoke with, who confirmed that she regularly worked on the ward and was aware of the care and support needs of the patients.

The registered manager told us that staffing levels throughout The Dene were now closely monitored to ensure that they reflected the assessed treatment and support needs of patients. She confirmed that staffing levels formed part of the daily agenda for the newly implemented morning meetings involving psychologists, occupational therapists, social workers and ward managers.

This was supported by minutes of recent morning meetings that we were shown.
Supporting workers  

Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

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**Our judgement**

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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**Reasons for our judgement**

Staff received appropriate professional development and were able, from time to time, to obtain further relevant qualifications. This was confirmed through discussions with management and staff and supported by records that we were shown, demonstrating the training staff had received.

On Michael Shepherd Ward staff confirmed that they work a 12 hour shift with a 2 hour break. We saw that although the ward appeared busy, staff were able to take their breaks.

On the staff rota we saw that 2 staff were attending the full 4-day MVA training this week, and the previous week one staff member had attended the refresher MVA training.

On Helen Keller Ward the manager told us that all permanent staff received monthly supervision and that appraisals were carried out annually. He told us that team meetings were held monthly. This was supported by staff we spoke with and by records that we were shown. The ward manager confirmed that all new staff must undertake initial Induction training which included control, restraint, life support, de-escalation and safeguarding followed by annual refresher training. A mentoring programme was in operation via Brighton University.

We spoke to a senior support worker who had worked at The Dene for over 11 years who stated, "I feel supported by my managers, I have no issues and have regular supervisions. If I do need to raise an issue I will speak to my managers - or other staff on other wards."

We spoke to a bank staff member who had only been working at The Dene for two weeks. They thought that the flexibility and family-friendly aspects at The Dene suited them as they were able to select which shifts they wanted. They confirmed that they had received some basic training such as food hygiene, self-harm, how to use the keys and radio but they felt that they 'had to learn on the job'. They said, "sometimes I have to work on my own initiative but my managers have been supportive and I enjoy this ward as I am getting to know the patients." They said that they had not yet received MVA (Management of Violence and Aggression) training or any medication training. They said that this maybe because they were bank staff.

A more experienced bank support worker who had been at The Dene for 3 years also
enjoyed the variety of working different shifts on different wards and said, "I am familiar with the patients on most of the wards." They stated that they fully understood the care plans and explained that handovers were usually over 30 minutes to check what has happened on the ward that day.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

People who use the service and their representatives were asked for their views about the care and treatment provided and they were acted on. Decisions about care and treatment were made by the appropriate care workers at the appropriate level.

We spoke with the regional contracts, IT & governance manager who informed us that The Dene had a robust clinical governance (CG) structure in place. It consisted of two meetings that feed into the corporate clinical governance meeting and shared the same agenda to ensure the companies values and initiatives were included. Other specialist local committees feed into the local CG structure, for example health and safety, security etc. We were told that the two local CG meetings had been structured to enable patients to be full time members of the process.

They included a user experience group, which had patients as permanent members and its agenda included: Local Patient Experience Initiatives; Patient Involvement Plans; Patient Council Feedback; My Shared Pathway and Real Work Opportunities. We were shown various examples of these processes, including Patient Involvement Plans; Patient Council Feedback and My Shared Pathway. The provider took account of complaints and comments to improve the service.

We were told that there were various ways that The Dene obtained feedback from patients, including: a satisfaction questionnaire, ‘designed to capture individual patients’ views on the information they have been given about the hospital and the services it provides; their care and treatment and their rights whilst detained under a section of the Mental Health Act 1983’.

In addition to patient surveys were the Patient Council; Involvement in Clinical Governance; Morning meetings; Care Programme Approach; Clinical Treatment Meetings and Therapy Planning.

This was supported by documentation that we viewed, including outcomes from patient surveys and minutes from recent Morning meetings.
We were informed by the Regional Contracts, IT & Governance Manager that surveys were also used to gather feedback from relatives and carers. He also told us that feedback from commissioners was routinely obtained through Contract review meetings, Care Programme Approach and Clinical Treatment Meetings.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<td>How the regulation was not being met:</td>
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<td>The service did not protect patients against the risks associated with the unsafe use and management of medication by means of appropriate arrangements for the obtaining, recording, using, safe keeping and safe administration of medicines.</td>
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This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us by 29 December 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

<table>
<thead>
<tr>
<th><strong>Met this standard</strong></th>
<th>This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action needed</strong></td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.</td>
</tr>
<tr>
<td><strong>Enforcement action taken</strong></td>
<td>If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.</td>
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</table>
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>13</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>14</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>16</td>
</tr>
<tr>
<td>Complaints</td>
<td>17</td>
</tr>
<tr>
<td>Records</td>
<td>21</td>
</tr>
</tbody>
</table>

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.