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

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

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### Overview of the service

The Dene is a modern purpose-built hospital providing specialised medium and low secure services for people with mental health needs, mild learning disabilities or problems with substance misuse.

The hospital has six wards, with a total of 84 beds, comprising one male and one female acute admission ward; two medium secure wards for women and one low secure service for women managed across two areas.

The nominated individual is Steven Woolgar. The registered manager is Sarah Shepherd.

### Type of service

Hospital services for people with mental health needs, learning disabilities and problems with substance misuse

### Regulated activities

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
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 30 April 2013, 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 use the service, talked with staff, reviewed information given to us by the provider and were accompanied by a pharmacist.

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

On the day of our inspection we were accompanied by Mental Health Act commissioners (MHAC), a Pharmacist Inspector and an Expert by Experience. We visited three wards (Edith Cavell, Helen Keller and Michael Shepherd) to monitor compliance and the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act.

We found that informal patients on an admission ward alongside detained patients were subjected to the same restrictions, which consequently infringed their rights. Patients also raised concerns about the lack of privacy and dignity.

The registered manager told us that the service had transferred much of its documentation, including individual care and treatment plans to an electronic system of recording.

Record keeping, including care plans, risk assessments and staff interventions were found to be inconsistent and inadequately maintained. Consent to treatment forms were not always in place.

One patient we spoke with on Michael Shepherd Ward told us "It would be good to have a few more staff around so we can get out more. Other than that I haven't got a bad word to say about the place".
We found that the service did not protect patients against the risks associated with the unsafe use and management of medication.

We found that patients' safety, welfare and their opportunity for leave was often compromised by insufficient staff on duty.

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

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What we have told the provider to do

We have asked the provider to send us a report by 25 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against The Dene to protect the health, safety and welfare of people using this service.

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.

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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

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

Action needed

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not respected. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

We have judged that this has a moderate 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

People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. Section 132 of the MHA relates to the duty of hospital managers to give information to detained patients about their rights and the effects of the Act. These should be given on a regular basis and a check should take place to make sure that patients fully understand their rights.

The Staff Nurse on Michael Shepherd ward told us that detained patients received information relating to their section and their rights were fully explained and discussed with them. This was confirmed by patients who we spoke with, however there was no documentary evidence of this made available to us.

On Edith Cavell we found evidence that patients were being informed of their rights but there was no way in which the patient could sign or otherwise indicate that their rights had been discussed with them. Without assurances that rights had been given, the provider could not demonstrate that patients knew about the reasons for their detention. In the computerised plans that we looked at it was not clear how patients had been involved in developing and reviewing them. There was very little evidence of the patients' views being included in the care plans and although plans sometimes started being written in the first person, by the end of the sentence the plan was in the third person. This was supported by a patient who told us that they had not been involved in their care planning. They told us: "I've not seen my care plan and have no idea where it is". Therefore not all patients were fully aware of or involved in their care and treatment.

'We were told that individual treatment plans could be printed from the electronic system. However, there appeared to be no identified process by which the patient could confirm
their agreement or disagreement with their plan on the computerised record. This meant that the provider was unable to demonstrate that patients were directly involved in making decisions about their care and treatment.

We were told by patients that the nightlights which are turned on in each patient's room to enable appropriate observation while sleeping were very bright. We were invited into one room by a patient, who closed the door and curtains. With the night light on it was light enough to read by. The patient told us it was difficult to sleep. A member of staff told us that this was so they could see the patient was still safe at night through the observation window, without opening the door, "which would disturb them".

Viewing panels on Edith Cavell ward and on Michael Shepherd ward were found to be locked open, with patients not able to control panels from inside their rooms for privacy and dignity. This was despite the issue being raised at the last inspection and the hospital policy stating that panels should be shut when the room is occupied.

We spoke to two patients on Helen Keller Ward who felt that the blanket ban on toilets being unlocked and the level of observation they were under was "undignified". "Toilets are locked at all times and we have to ask the nurse to open the toilet which might involve a lengthy wait. We are also supervised and not able to go to the toilet on our own".

Four patients on Helen Keller Ward told us that they were supervised when taking a shower and felt that this compromised their privacy, dignity and independence. They were also unhappy about their bedroom doors being locked during the day.

Another issue raised by patients on Helen Keller Ward was that the mix of gender of staff was not always appropriate. Comments received from the female patients included "Too many men on at night", made them feel "uncomfortable."

A Director at The Dene informed us that "There is not a written policy regarding room locking or toilets being locked off – the wards operate taking into account the risk presented. A large proportion of patients on the ward present with self harming behaviour and this is usually carried out in lone areas such as bedrooms / bathrooms / toilets. A number of the patients will be subject to enhanced observations as a consequence of their high risk - others may not respond well to this as it can encourage high levels of interdependence, so the environment itself is restricted to maintain safety for such cases".

With patients unable to access their rooms during the day, we observed many of them sitting together in the communal areas. One patient told us that she was unhappy with this situation: "The ward is too noisy with no personal space to get away from incidents which happen every day".

A member of staff on Edith Cavell ward told us that smoking breaks were provided six times a day but that sometimes the breaks were cut "if patients haven't been very good". They said "It doesn't seem very fair. It's not common practice but it does happen".

We were told about the "Red – Amber - Green" (RAG) system for assessing risk and subsequently determining access to different parts of the ward. A care worker told us that patients on 'green' had access to their rooms whenever they wanted and had their own keys. Those on 'red' and 'amber' had to ask staff for access to their rooms. A care worker told us that patients on "less secure colours" had greater access to clothes and personal
items, while those on 'red' were 'very restricted'. Another care worker told us "Leave seems to be more about cigarettes - it is used as a punishment. Cigarettes are used as reward and for bartering – it's ridiculous". This meant that the independence, privacy and dignity of patients was not always being respected.

A patient who had been on the ward for almost six months told us that on occasions a male member of staff had walked into her room whilst they was getting dressed as they can't lock their door from the inside. A care worker we asked about this issue said that male staff did not enter a room if people were getting dressed or in the shower and, if necessary, they would get a female member of staff. Another care worker confirmed that this was the case. This demonstrated again that the privacy and dignity of patients was not always respected.

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.

During our visit we were invited to join one of these meetings on Edith Cavell ward, where the topics discussed by patients and staff included the news that three patients were actively moving to the next stage of their care programme, the various activities that would be taking place that day and later in the week; and the availability of paid work on the ward. (One person had been appointed to participate in staff interviews which would be taking place later in the week, and more job roles were said to be available). This demonstrated that people using the service were enabled to be involved in how the service was run.
Consent to care and treatment  

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

Our judgement

The provider was not meeting this standard.

Before people received any care or treatment they were not always asked for their consent.

We have judged that this has a moderate 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

Before people received any care or treatment they were not always asked for their consent and therefore the provider did not act in accordance with their wishes. On Helen Keller ward some improvement since the last inspection in November 2012 was observed in the recording of capacity to consent to treatment. However this was found not to be consistent on admission of patients or on an ongoing basis. Inconsistency was seen in the use of the current capacity to consent form both in the notes and on the electronic patient record.

We looked at six care plans that included both written consent forms and computerised records. We saw completed consent forms in all individual plans. The CQC pharmacist also checked this outcome.

We asked patients if they were asked to consent to treatment. We received varied responses. Two patients said they had been asked and they had agreed to their treatment plan. One patient said, "I want to leave here and get my life back, so I agreed to the treatment and restrictions." Two others told us that they felt as if the decisions had been made on their behalf "in our best interests" whilst another patient said they were just told what was going to happen. However we found that there was little recorded evidence that any discussion or agreement had taken place between staff and individual patients.

On Edith Cavell ward we found no evidence of patients' wishes or feelings being documented. One patient told us that they had made a statement of how they wished to be helped when distressed. However we found that there was a note in their records stating that this had been lost but it had not been replaced.

We looked at four care plans on Michael Shepherd ward. We viewed the plans on a computer as part of the recently implemented 'Electronic Patient's Records'. In three of the plans that we saw the patient had been admitted to The Dene within the past three months and consequently did not require a consent form to be in place. However in the fourth plan we could find no trace of a consent form and the staff were unable to locate it. Although they assured us that the form had been completed, this could not be confirmed.
This meant that the provider did not always have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people using the service, in relation to their care and treatment.
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 not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People's care and treatment was not always planned and delivered in line with their individual care plan.

A paper by the Royal College of Psychiatrists, (Do the right thing: how to judge a good ward. Ten standards for adult in-patient mental healthcare) published in June 2011 stated that: 'Undue restrictions on a patient's autonomy compromise their personal dignity and rights as an individual. Such excessive restrictions are upsetting for the patient and can delay recovery).

Michael Shepherd Ward was the only acute admission ward that we visited. A senior member of staff told us that the ward currently accommodated both detained and informal patients and therefore "balance was needed". They said that informal patients were able to go downstairs and out through the front door, although the need for locked doors was "unavoidable".

However we were concerned about the impact that environmental restrictions had on informal patients. We saw that in order for an informal patient to go out through the front door of the hospital, they would need to pass through two security 'air locks'. This would clearly only be possible if there were staff available to escort them.

This contradicts The Dene's own policy, Management of Informal Patients' which stated "If an informal patient wishes to leave the clinical area, staff should have regard to the completed risk assessment. If the risk assessment and current presentation of the patient suggests that there are no grounds for preventing the patient from leaving, then he/she should be allowed to". This meant that informal patients were prevented from leaving as they wished. This restricted their independence, did not follow principles of personalised care and was contrary to the providers own policy.
We saw that a printed 'ward information' sheet was displayed in the communal area showing prescriptive times for the garden, drinks and activities. There was also a weekly therapeutic activity timetable. The only event listed for mornings – apart from visiting the ward shop on Wednesday – was the community meeting. However several of the patients we spoke with said that this meeting rarely happened. This demonstrated that the planning of care, treatment and support did not always meet the individual needs of people who used the service.

On Helen Keller Ward we were told by a nurse that care plans were being scanned and archived as the service was now using a computerised care plan. However we found that the computerised care plans lacked initial diagnosis and the reason for admission, any history of past treatment and any information relating to family and personal relationships. We were told that all this information had been scanned and archived, but was not readily available from the database. This meant that the planning of care and treatment did not ensure the welfare and safety of people using the service because their relevant medical history was not available to staff.

We saw evidence that patients' weight, blood pressure, pulse and temperature were being monitored but that irregular recordings were not picked up or investigated. Some examples of this were low blood pressure readings and raised pulses. They were recorded but not investigated where there were concerns and no further action had been recorded or taken.

We discussed this with the deputy unit manager who could not explain the lack of follow through action. They suggested that the readings were possibly due to "medication or faulty equipment". While we were there the equipment was tested and gave false readings and calibration. A second machine was tested but was not working as the batteries were flat. This meant that people using the service were at risk of receiving unsafe or inappropriate care or treatment because concerns were not being followed up or actioned where necessary.

Individual care plans and treatment plans that we looked at did not demonstrate a person centred approach and did not accurately reflect the care and support delivered. We found little information about emotional support and family involvement. There was also no mention of how staff supported people with personal care should they be on continued supervision.

We were informed that a patient was refusing to eat and there was evidence that a dietary supplement was being supplied. However not all staff were aware of this. One care worker we spoke with said that the supplement was no longer required, whilst another staff member said the patient had it everyday. We saw that the dietician was involved in the treatment of individual patients. We also saw that specialist dietetic advice had been sought, however this information had not been transferred to the main computerised care plan. This meant that people using the service were at risk from unsafe or inappropriate care and treatment because staff were not aware it this individual's care needs.

We looked at how the service dealt with unforeseeable emergencies. There were fire evacuation plans in the unit that identified how to evacuate in the event of fire. Staff we spoke with knew where the meeting places were.

The medical emergency equipment was in place, however we found that it was not ready
for use and would not be easily assessable. The oxygen bottle was inside two different bags and did not have tubing or a mask attached. The oral airways were unsealed and underneath other equipment.

A nurse told us that all emergency equipment was checked daily and documented. They said that the ligature cutters were kept securely in the hallways in locked cupboards. However two trained members of staff could not locate the adrenaline when asked. The senior trained nurse on duty did eventually locate it, after much discussion and searching. We saw that there was a defibrillator in the treatment room, but two staff nurses were not trained in its use. This meant that people using the service were not always protected from unsafe care or treatment because staff did not always know how to use emergency equipment or where it was.

Patients on Helen Keller Ward who we spoke with were unhappy about being locked out of their room all day. They said "A blanket ban of being locked out of the bedroom area from 8.00 am to 8.00 pm is unfair and too restrictive. We are supposed to have a one hour rest time in our room but this never happens. So patients have to sit around in the communal area with not a lot of activities, which causes friction as there is no personal space".

The use, on Helen Keller Ward, of a blanket approach to the locking of bedroom doors and the lack of adequate individual risk assessment demonstrated that the service was not treating patients as individuals and showed a lack of personalised care planning.
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.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We looked at medicine management in three areas in this service. The provider had not reviewed the policies and procedures on medicines handling which had a review date of June 2012.

Each of these areas had a medicine storage room and medicines were locked away. We noted that in one of these areas the controlled drugs cupboard did not comply with the requirements of the Misuse of Drugs Regulations 1973. Each of these rooms had a red bag which contained equipment for resuscitation. The practice nurse employed by the service regularly audited the contents of this bag. The oxygen cylinder was available but not prepared ready for use. Staff told us that their training for life support was to basic level only. Not having the correct resuscitation equipment for people may put them at considerable risk at a critical time.

Medicines were not disposed of appropriately. We saw medicines for people no longer in the service within the locked cupboard. These should have been disposed of appropriately. We saw in one area that records of medicines for disposal were not kept up to date. This is contrary to the medicine policy of the service.

Appropriate arrangements were not in place in relation to obtaining medicine. There was a top-up system for regularly used medicines. A member of staff from the pharmacy visited once a week to go through the medicines against a pre-agreed stock level list and order medicines to that level. This list contained mainly medicines used for mental health needs. When the order is received into the service there is no record of medicines received. Additional medicines and medicines for physical health were ordered on an FP10 (the national health green prescriptions). All the patients had been registered with the local doctor.

We saw that, for two people, medicines for physical health needs were out of stock for up
to two weeks. The provider told us that the medicines were ordered but not delivered. The provider could not show us evidence this. This meant that the people were left without these prescribed medicines which could have put their health and welfare at risk.

Appropriate arrangements were not in place in relation to the recording of medicine administered. We saw several gaps in the treatment charts for when medicine was prescribed to be taken. We could not check from stock if this medicine has been given as these medicines were stock items. Not having true and accurate records of prescribed medicine administered meant the provider could not evidence the medicines were given to people appropriately.

We looked at the medicines which were prescribed to be administered only when needed. We had stated in our report following out previous inspection in late 2012 that there were no clear instructions on the use of these medicine. A member of staff told us that the decision to administer these ‘when required’ medicines would be a professional judgement. The policy on these ‘prn’ medicines is clear on how they are to be used. The policy states that the doctors must indicate the reasons for the medicines. The doctor did not give the specific signs to note to decide to give these medicines. This means the use of these ‘when required’ medicines would not be consist and depended on the member of staff present.

We watched people being given their lunch time medicines in one of these areas. The process used followed a safe practice. People came to the hatch of the medicine storage room and were given their medicines. Staff engaged with the person and ensured the medicine was swallowed before signing the treatment chart.

We noted that action was not taken to follow up on information gathered from audits. For example one resident had consistently high blood pressure and low pulse. This had not been followed up. However we were given assurances that ‘Action is taken following audits but this is not recorded robustly’.

We were told that the fridge had been repaired on the day of our visit. However, high temperatures that had been recorded one month previously had not been reported for over a week, according to the records we were shown. We saw that medicine administration records charts were audited. However there was no recorded evidence that any shortfall seen from these audits were addresssed. This meant staff were not taking responsibility to address information gathered from audits and this may put people at risk to their health and welfare.
Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people’s needs.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the ‘Enforcement action’ section within this report.

Reasons for our judgement

There was not always enough qualified, skilled and experienced staff to meet people’s needs. The Department of Health Mental Health Policy Guide regarding Acute Inpatient Care Provision states that ‘Shortages of staff, lack of the skills, attitudes and knowledge required, high staff turnover, and over-use of bank and agency nursing staff, all contribute to low staff morale and mitigate against the development of a safe and therapeutic ward culture’.

As with other outcome areas we found that there were some inconsistencies between the wards that we visited regarding staffing levels. However a common concern raised by both patients and staff was the impact that staff shortages had on therapeutic activities and recreational opportunities for patients. This was particularly evident in respect of patients’ access to leave, which was described by a senior nurse as "compromised by staffing levels".

The Director showed us details of the number of staff who had left The Dene over the last 12 months as well as the number who had started work at the hospital during the same period. We saw that there had been 19 qualified nurses leave and 17 nurses start work. We noted that there had also been a fairly high turnover of Health Care Workers (HCW) with 18 HCWs leaving The Dene and 27 being appointed within the last year.

Michael Shepherd ward is a male acute admission ward with 16 beds. We were told that on the day of our inspection there were 13 people on the ward (10 detained and three informal patients). We found that on the day of our inspection there were four staff on duty – two qualified nurses, one who was a bank nurse and the other was supplied from an agency, and two health care workers - with one care worker ‘floating’ between Michael Shepherd Ward and Edith Cavell Ward. However we were told by the Deputy Charge Nurse that when the ward was full there would be five staff on duty.
A patient on Michael Shepherd Ward told us "It would be good to have a few more staff around so we could get out more but other than that I haven’t got a bad word to say about the place”.

Helen Keller Ward is a medium secure unit with 17 beds. On the day of the visit, there were 13 female patients, all detained under the Mental Health Act 1983 (MHA). Two qualified staff and five support workers and one bank staff member were on duty on the day of our inspection. During the night the number of staff was reduced to seven. Although eight members of staff were on duty, we saw that four staff were carrying out one to one observations on individual patients and were therefore unavailable to carry out day to day duties. This meant that if an emergency or incident occurred whilst one of the other care workers was on their break, there would be insufficient staff to manage the situation and people’s safety would be at risk.

A patient said "Most of the staff are friendly, but they are always too busy and never have enough time to give one to one time to listen to concerns".

Another patient told us "Leave is cancelled at short notice or walks in the grounds do not happen due to staff not being available"

Detained patients can only lawfully leave a hospital if they are given leave of absence by their responsible clinician under section 17 of the Mental Health Act and therefore the lack of staff had a direct impact on their opportunity to leave the ward.

On Helen Keller Ward we spoke with six patients and four staff. They also told us that not enough staff around during the day meant that so they sometimes cannot go to their bedroom during the day.

Staffing rotas that we looked at did not correspond to the updated computerised staffing allocation. Senior staff who we spoke with did not know who was on duty.

We were told that staffing levels could change if staff were required elsewhere, which would impact on the level of support and supervision on the ward. One staff member told us "If staff are moved, it means our patients may not get their walk or cigarette ".

We saw that at times of incidents involving other patients, others were left sitting around with no interaction or activities to occupy or distract them. Consequently they focused on an incident that we witnessed and some of the other patients then became unsettled and aggressive.

Edith Cavell Ward is a low secure unit and there were 13 patients at the time of the inspection. Four care staff were on duty, including the nurse ward manager, and we were told that there were four staff on duty at night.

A health care worker said "We are understaffed. The RMNs go 12.5 hours without a break. It's a long time". They also told us that there was a lack of consistency as staff were often moved to other wards to provide cover.

We asked a care worker why The Dene had problems with staffing. They told us "They don’t look after staff. People are tired and run down and if there were more staff around, more patients could go out on escorted leave and there would be less trouble and less sickness".
One member of staff on the ward told us the staffing levels fluctuated. Sometimes they were "very short staffed". They said that wherever possible they would like to encourage patients to be out in the community but this was "not always possible". This meant that there was not always enough qualified, skilled and experienced staff to meet people's needs.

They also told us that they rarely get a break and worked "7.30am to 8pm most days". They said that staffing is a problem. They told us "It is very tiring and there's always pressure when patients who want leave can't go out because of the lack of staff". They described the pressures as "constantly juggling".

A member of staff said that on paper there were enough staff but actually they need one more member of staff to cover the breaks that are taken throughout the day. They said that Edith Cavell was a more settled ward and therefore staff were often taken from there to cover other wards. They told us "It's not ideal but there is not much they can do about it".

As there were insufficient staff on all three wards, the provider was not able to effectively safeguard the health, safety and welfare of patients.
Supporting workers

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

Action needed

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not always supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate 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

On Edith Cavell ward a care worker told us that they were first aid trained and that they were required to complete the induction training on an annual basis. This covered basics such as moving and handling, diversity, safeguarding, and Management of Violence and Aggression. They said "the induction is very thorough" but they had not had a one to one for over seven years. They said that there is a staff group meeting held each Wednesday.

Another care worker told us that they had never attended a team meeting or had supervision or one to ones in the 8 months they had worked at The Dene. They said that if they had a problem they would go to a more experienced colleague for help rather than a manager as they "can never get hold of them". An issue they raised was that when they requested leave via email "nobody responds". They gave an example of a specific urgent request for leave but got no reply to their request. This meant that staff are not properly supported or supervised.

They said that they believed there was a high turnover of staff because "people feel undervalued and the work is too stressful". They said "the charge nurse rarely had a break and regularly works a 12.5 hour shift".

They also told us that they didn't get Management of Violence and Aggression (MVA) training until they had been in post over four months and believed they were "working unsafely". They said "they really throw you in blind and there is not enough support". They told us that they hadn't really had much training of the Mental Capacity Act or the Mental Health Act.

During our inspection we spoke with a manager in Human Resources (HR) who told us that staff training provision throughout the hospital was given a "high priority". We were shown comprehensive computerised training records for all staff at The Dene. The matrix was well maintained and indicated the dates that each individual had received specific training.
The HR manager told us that staff training in respect of the electronic patients records had been 'rolled out' for all care workers and that this process had only recently been completed. However a care worker we spoke with acknowledged that there had been some 'teething problems', including locating certain information. They described the system as "work in progress".

They said "the training is really good". They told us that the ward was supposed to have a team meeting every two weeks but the last one was in February. They also said that minutes of these meetings were taken and "should be in the shared drive". However despite requests to see them, they were not made available.

A nurse told us that they did meet with their manager regularly, the deputy nurse but "you have to push to get a meeting". They said that there were no regularly booked one to ones and their last was about three weeks ago. They told us that they had received an annual appraisal this year.

A senior nurse told us that there was a lot of informal supervision provided to staff, including 'reflective practice' but this was not being diarised or recorded on the electronic system.

An assistant occupational therapist told us that the team have quarterly planning meetings. They told us that they have formal supervision every fortnight and informal one to ones as necessary, "It is timetabled into my week". They said that they also had "reflective practice" once a month and a team meeting weekly, where minutes were taken. They said that communication was good and they always knew what was going on. They said that they were happy to talk to their supervisor if they had any serious concerns.

This meant that support for staff was inconsistent applied and not all staff were appropriately supported. This contradicted The Dene's supervision policy which stated: 'All wards are to manage their own supervision process and record any formal or informal sessions within the local electronic supervision register'.
Records

**People's personal records, including medical records, should be accurate and kept safe and confidential**

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Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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

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Reasons for our judgement

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Many of the patient records that we looked at during the inspection had been transferred to a recently implemented electronic system, which staff were still getting used to.

On Edith Cavell ward it was sometimes difficult to identify how the care plans were related to the risks that had already been identified, and some plans were general in nature so that, for example, a nurse unfamiliar with the ward would not find them particularly useful.

On Helen Keller ward we found similar concerns regarding the computerised care plans. The care plans viewed on the electronic system did not record staff guidance regarding interventions or evidence of patient views regarding their plan. The plans recorded what the staff intended to assist the patient with but did not fully identify the patient's views about that action. Also the electronic care plan had no provision to record the patient's agreement or signature. A nurse explained that this was "one of many problems with the new system".

Although we found some evidence of risk assessments being undertaken this was not consistently recorded on the system. There was also insufficient recorded evidence of the patients' involvement during the risk assessment and insufficient evidence recorded of risk reviews following incidents.

On Michael Shepherd ward there was no documentary evidence made available to us to indicate that patients had had their rights explained to them. In care plans that we saw, Section 132 rights were not recorded as having been given to patients. We also found a concerning lack of information in individual care plans and electronic patient records that we were shown.

In care plans that we looked at we saw no evidence of the individual's personal or medical history and were told by a care worker that this information had been 'archived'. Staff
interventions were found to be brief 'bullet points' with no supportive guidance available. An example of this was a reference to assisting a patient 'with stoma care' with no additional details in place for new care workers or agency staff, unfamiliar with the routines of the ward.

We found that the Seclusion Record was particularly poorly maintained. There were gaps in the recording of information, including times of doctors' and consultants' visits and the name and designation of the person who terminated the seclusion. We also saw that in three cases there was no date or signature for the termination of seclusion. This effectively meant that the seclusion was still on going. We also found several entries in the register that showed seclusion had been terminated. However there was no indication as to who had terminated the seclusion and there were no signatures in place for the doctor or senior nurse.

This meant that people using the service were not always protected from the risk of unsafe or inappropriate care or treatment.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Respecting and involving people who use services</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered person did not make suitable arrangements to ensure the privacy, dignity and independence of people using the service. Informal patients were subjected to the same restrictions as detained patients. People using the service were not always aware of or involved in making decisions relating to their care and treatment. Regulation 17 (1) (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Consent to care and treatment</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people using the service. Consent to treatment forms were not always in place. Regulation 18.</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Regulation</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Supporting workers</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met: Staff were not always supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Records</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met: The registered person did not always ensure that people using the service were protected against the risk of unsafe or inappropriate care and treatment. Record keeping, including care plans, risk assessments and staff interventions were found to be inconsistent and inadequately maintained. Regulation 20 (1) (2).</td>
</tr>
</tbody>
</table>

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 25 August 2013.
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.
Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

**We have served a warning notice to be met by 28 June 2013**

This action has been taken in relation to:

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The planning and delivery of care, treatment and support did not always meet the individual needs of people using the service. Regulation 9 (1) (2).</td>
</tr>
</tbody>
</table>

**We have served a warning notice to be met by 21 June 2013**

This action has been taken in relation to:

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>How the regulation was not being met:</td>
</tr>
</tbody>
</table>
Diagnostic and screening procedures  
Treatment of disease, disorder or injury  

The registered person was failing to protect people using the service against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for handling of medicines used for the purposes of the regulated activity. Regulation 13.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Staffing</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Patients' safety, welfare and their opportunity for leave was often compromised by insufficient staff on duty. Regulation 22.</td>
</tr>
</tbody>
</table>

For more information about the enforcement action we can take, please see our Enforcement policy on our website.
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 other services less often. 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.

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>✔️ Met this standard</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>✗ Action needed</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>✗ Enforcement action taken</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>
</tr>
</tbody>
</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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

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.