

## Partnerships in Care Limited

# The Dene

### Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations.

### Ratings

#### Overall rating for this hospital

Requires improvement



Acute wards for adults of working age and  
psychiatric intensive care units

**Requires improvement**



Forensic/inpatient/secure wards

**Requires improvement**



# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

We rated safe as **requires improvement** because:

- There was a high level of vacancies on the wards which resulted in agency staff being used to cover many shifts and caused an inconsistency in patient care.
- Risk assessments were not fully updated.
- Physical healthcare checks, especially after the use of physical interventions were not always carried out as required.
- There were blanket restrictions in place on all wards.
- Staff carrying out one-to-one observations on patients did not receive the breaks required in the hospital's own policy or the National Institute for Health and Care Excellence (Nice) guidelines.
- Some patients had to be restrained and escorted through several doors and up and down stairs in order to be taken to the seclusion facilities, due to the layout of the building.

However:

- Wards were clean and environmental risks were recorded and managed.

Requires improvement



### Are services effective?

We rated effective as **requires improvement** because:

- Care plans were not always fully updated and patient centred.
- Recordings of physical healthcare checks were inconsistent.
- Agency staff received induction training on the hospital safety processes but were only given a verbal hospital induction.
- Not all staff received regular clinical supervision or appraisals.

Requires improvement



### Are services caring?

We rated caring as **good** because:

- We saw multiple examples of positive and appropriate attitudes by staff towards patients during the inspection.
- Patients told us that they liked the staff.
- Patients told us that the staff treated them fairly and all comments were positive.

Good



# Summary of findings

- The comment cards we received reported that the staff were caring and attentive.
- There was good rapport between the patients and the staff. Staff members recognised and understood the individual needs of the patients.

## Are services responsive?

We rated responsive as **requires improvement** because:

- There was no information available on the wards in different languages for those who required it.
- Patients who used wheelchairs had to use a different outside space to other patients because the courtyard was not accessible to people who used wheelchairs.

However:

- Information about patients' rights, access to an advocate, how to complain, activity timetables and community meeting minutes were available to patients on the wards.

**Requires improvement**



## Are services well-led?

We rated well-led as **requires improvement** because:

- The governance processes were not identifying and addressing where the wards were not operating in line with the providers policies and procedures.

However:

- The hospital had quality dashboards in place to set objectives and monitor performance.
- The corporate medicine management policy had been reviewed in May 2015 and was supported by procedures which were all in date.
- Staff reported that they felt able to bring issues to the attention of the senior management team

**Requires improvement**



## Mental Health Act responsibilities

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

Detention paperwork was generally in good order and patients were informed of their rights under the Mental Health Act.

Staff we spoke with had a good working knowledge of the Mental Health Act and the relevant sections relating to the patient group.

# Summary of findings

Medication cards had copies of consent to treatment forms appropriately attached.

There was a Mental Health Act administrator based within the hospital and staff felt confident they could approach them with any issues relating to the MHA.

All patients did not have access to lockable space for their belongings.

The use of seclusion did not comply with the hospital's seclusion policy or the Mental Health Act Code of Practice. For example, the multidisciplinary reviews of seclusion did not always include a full multidisciplinary team and did not always take place at the times or intervals stated in the hospital's policy or the Code of Practice.

Patients were required to wear tear-proof clothing as standard practice whilst in seclusion contrary to the Mental Health Act Code of Practice.

## **Mental Capacity Act and Deprivation of Liberties Safeguards**

The staff we spoke with did not have a good awareness of the Mental Capacity Act and its guiding principles. One person told us they were not aware of the Mental Capacity Act and another described the Mental Capacity Act as being predominantly to do with managing patient finances. The staff told us they did not have regular training in the Mental Capacity Act other than 15 minutes on mental health act information during their first week of induction.

The staff did not refer to any policy relating to the implementation of the Mental Capacity Act, however the Dene had updated their Mental Capacity Act and Deprivation of Liberty policy in May 2015.

We did not observe any capacity related documentation or discussion evidenced in any of the care and treatment records we observed during the inspection. The staff we spoke with were not aware of any capacity assessments having taken place or being documented. There was no evidence, in the notes checked of patients on the temporary learning disabilities ward, of any capacity assessments or best interest meetings having taken place. However, the temporary learning disabilities ward had been set up at short notice by request from NHS England and did not have a team experienced in working with people with learning disabilities. The ward closed, as planned, a few weeks after our inspection.

# Summary of findings

## Our judgements about each of the main services

### Service

**Acute wards for adults of working age and psychiatric intensive care units**

### Rating

**Requires improvement**



### Why have we given this rating?

We rated The Dene as **requires improvement** because:

- There was a high level of vacancies on the wards which resulted in agency staff being used to cover many shifts and caused an inconsistency in patient care. The staff shortages led to increased pressure on staff, it was difficult for ward staff to plan patient activities each day and some staff were not getting regular breaks. The staff shortages also meant that not all staff received regular supervision or appraisals because there were vacancies in line-manager posts and many of the ward managers were very new in post.
- Risk assessments were not fully updated. There were insufficient systems in place to ensure risk assessments were updated following incidents.
- Care plans were not always fully updated and patient centred. There were insufficient systems in place to ensure care plans were fully updated and patient-focused.
- Recording of physical healthcare checks were inconsistent.
- There were blanket restrictions in place on all wards.
- Patients who used wheelchairs had to use a different outside space to other patients because the courtyard was not accessible.

However:

# Summary of findings

- Patients told us that the staff treated them fairly and all comments were positive.
- There was good rapport between the patients and the staff. Staff members recognised and understood the individual needs of the patients.
- The hospital had governance plans and quality dashboards in place to set objectives and monitor performance.
- Staff felt able to raise issues to the senior management team.

## Forensic inpatient/ secure wards

### Requires improvement



We rated The Dene as **requires improvement** because:

- There was a high level of vacancies on the wards which resulted in agency staff being used to cover many shifts and caused an inconsistency in patient care. The staff shortages led to increased pressure on staff, it was difficult for ward staff to plan patient activities each day and some staff were not getting regular breaks. The staff shortages also meant that not all staff received regular supervision or appraisals because there were vacancies in line-manager posts and many of the ward managers were very new in post.
- Risk assessments were not fully updated. There were insufficient systems in place to ensure risk assessments were updated following incidents.
- Care plans were not always fully updated and patient centred. There were insufficient systems in place to ensure care plans were fully updated and patient-focused.
- Recording of physical healthcare checks were inconsistent.

# Summary of findings

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**However:**

- Patients told us that the staff treated them fairly and all comments were positive.
  - There was good rapport between the patients and the staff. Staff members recognised and understood the individual needs of the patients.
  - The hospital had governance plans and quality dashboards in place to set objectives and monitor performance.
  - Staff felt able to raise issues to the senior management team.
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Requires improvement 

# The Dene

## Detailed findings

### Services we looked at

Acute wards for adults of working age and psychiatric intensive care units;

Forensic inpatient/secure wards

# Detailed findings

## Contents

Detailed findings from this inspection	Page
Background to The Dene	8
Our inspection team	8
How we carried out this inspection	8
Our ratings for this hospital	8
Findings by main service	11
Areas for improvement	30
Action we have told the provider to take	31

## Background to The Dene

The Dene is an independent hospital run by Partnerships in Care, based in West Sussex. It takes referrals from anywhere within the country.

The Dene is registered under the Health and Social Care Act 2008 to provide the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury; and diagnostic and screening procedures.

The Dene has a registered manager.

The Dene provides medium and low secure services for females and an inpatient service for women with high dependency needs (a high dependency unit). They also provide an acute service for men and at the time of our inspection had a temporary ward for males with learning disabilities in order to take patients from two recently closed hospitals in the area.

At the time of our inspection there were six wards in use:

Amy Johnson ward - a 12 bed female medium secure ward;

Elizabeth Anderson ward - a 16 bed female medium secure ward;

Michael Shepherd ward - a 16 bed female low secure ward;

Edith Cavell ward - an 18 bed male acute mental health ward;

Helen Keller ward - a 12 bed female high dependency acute mental health ward;

Wendy Orr ward - an eight bed temporary male ward for people with learning disabilities.

The Dene has been inspected three times previously by CQC, in November 2012, April 2013 and October 2013. At the last inspection in October 2013 the location met all essential standards inspected.

At the time of our inspection, there were 5 patients temporary on Wendy Orr ward. We inspected this ward but have not reported on this as it was closed two weeks after the inspection.

## Our inspection team

The team that inspected The Dene consisted of an inspection manager, three inspectors, a pharmacy inspector, a Mental Health Act Reviewer, a specialist advisor with experience of working in acute and secure

mental health services, a specialist advisor with experience of working in learning disability services and an expert by experience, who has experience of using or caring for someone who uses services.

# Detailed findings

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited five of the wards at the hospital and looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 31 patients who were using the service;
- spoke with one family member of a patient using the service;
- interviewed the managers or acting managers for each of the wards;
- interviewed 15 other staff members; including doctors, nurses, support workers and occupational therapists;







- interviewed the divisional director with responsibility for these services;
- attended and observed three morning hand-over meetings;
- attended and observed one multidisciplinary handover meeting;
- attended and observed one multidisciplinary team meeting;
- attended and observed two care programme approach meetings;
- observed a ward lockdown and search procedure;
- collected feedback from 17 patients using comment cards;
- looked at 35 care records of patients;
- looked at cleaning schedules for all wards;
- looked at seclusion records for all wards;
- carried out a specific check of the medication management on all six wards;
- carried out a specific check of the use of seclusion and long-term segregation;
- looked at a range of policies, procedures and other documents relating to the running of the service.

## Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Forensic inpatient/secure wards	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

# Acute wards for adults of working age and psychiatric intensive care units

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

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# Acute wards for adults of working age and psychiatric intensive care units

## Summary of findings

We rated The Dene as **requires improvement** because:

- There was a high level of vacancies on the wards which resulted in agency staff being used to cover many shifts and caused an inconsistency in patient care. The staff shortages led to increased pressure on staff, it was difficult for ward staff to plan patient activities each day and some staff were not getting regular breaks. The staff shortages also meant that not all staff received regular supervision or appraisals because there were vacancies in line-manager posts and many of the ward managers were very new in post.
- Risk assessments were not fully updated. There were insufficient systems in place to ensure risk assessments were updated following incidents.
- Care plans were not always fully updated and patient centred. There were insufficient systems in place to ensure care plans were fully updated and patient-focused.
- Recording of physical healthcare checks were inconsistent.
- There were blanket restrictions in place on all wards.
- Patients who used wheelchairs had to use a different outside space to other patients because the courtyard was not accessible.

However:

- Patients told us that the staff treated them fairly and all comments were positive.
- There was good rapport between the patients and the staff. Staff members recognised and understood the individual needs of the patients.
- The hospital had governance plans and quality dashboards in place to set objectives and monitor performance.
- Staff felt able to raise issues to the senior management team.

## Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement



### Safe and clean environment

- There were clear lines of sight on both Edith Cavell and Helen Keller wards. Staff were able to observe patients in communal areas and their bedrooms. Bedroom doors had viewmatic windows that allowed staff to observe and then shut to maintain dignity. Dome mirrors were in place on the ceilings of the wards so that staff could observe blind areas more easily without a physical presence. Both wards had ligature assessments that clearly identified ligature risks and how they should be managed although staff we spoke to had not seen a copy of the ward ligature audit and were unable to comment on whether they felt it was appropriate to manage the risks of the client group.
- Ligature cutters were stored safely and staff told us where to get them from if required.
- All bedrooms had en suite bathrooms. Wards were single sex and all patients had their own rooms.
- Medicines were stored securely. Records were made of medicine refrigerator and room temperatures on a daily basis and these were all within the expected temperature ranges.
- The contents of the emergency medicine bags were checked regularly by hospital staff; all contents were found to be in date.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. The Standard Operating Procedures for Controlled Drugs had been reviewed and updated in 2015. Incidents involving controlled drugs were reported via the incident reporting system, these were investigated by the accountable officer for controlled drugs and records made of the actions taken.
- A pharmacy service was provided by an external contractor. The contracted pharmacist conducted a

# Acute wards for adults of working age and psychiatric intensive care units

missed dose audit on a monthly basis, which looked at three prescription charts from each ward. The hospital did not conduct regular audits of out of stock medicines.

- There was inconsistent recording of the allergy status of patients.
- There were not seclusion rooms on all wards resulting in wards sharing the facilities. Two of the seclusion rooms were situated up a flight of stairs on the first floor. Staff reported that the upstairs seclusion rooms were better designed and more appropriate to the needs of the patients and they were therefore the ones that were prioritised for use. Staff on some wards were therefore put in a situation when they needed to restrain patients. They had to escort them through several doors and up and down stairs in order to access seclusion. All clinical staff who were MVA trained covered movement up and down stairs in their annual MVA training.
- Edith Cavell and Helen Keller wards were clean but there were areas where paint was peeling off the wall, particularly in the clinic room.
- Patients and staff told us that the patients did not have keys for their bedrooms or for the lockable space in their bedrooms, this meant that if patients did not ask staff to lock their room other patients could access their bedrooms. Patients told us they would like to have keys for their rooms but they were not concerned about their possessions going missing.
- Risk assessments of the environment were undertaken each shift by the nurse in charge of security, this nurse was also in charge of knowing the whereabouts of each patient and staff member and keeping a log of movements on and off the ward.
- The ward had a weekly security folder which gathered together all the processes for checking the environmental and procedural security of the ward. Staff told us they found the security folder complicated and difficult to navigate due to the large number of pages per day that needed completing.
- There were call alarms for staff and patients, staff were issued with personal alarms prior to starting the shift. Identified staff members were allocated as first responders to incidents in the hospital.

- There were handwashing signs in appropriate places around the wards.
- The cleaning schedules showed that regular daily cleaning was being done and the schedules indicated this was being well audited by the domestic manager.
- Staff told us they were not involved in any environmental risk audits or risk assessments, as these were completed by the nurse in charge.

## Safe staffing

- The data provided by the hospital prior to our inspection stated that in acute services there was a 44% vacancy rate for qualified nurses (7.4 vacancies out of a total of 17 whole time equivalent positions). There was a 25% vacancy rate for nursing assistants (8.5 vacancies out of 33.5 whole time equivalent positions). The hospital had a 29% turnover rate for staff.
- The hospital director told us that recruitment was their priority and the hospital had a recruitment strategy and plan. The hospital was permanently recruiting for qualified nurses and nursing assistants. However, the hospital director told us that the national shortage of qualified mental health nurses and the particular challenges of recruitment locally meant that the hospital continued to have a staff shortage. The hospital had to rely on agency staff, some of which were on longer-term contracts, to fill the nursing posts to a safe staffing level on a daily basis. All wards had 4 staff on shift a day, 2 being RMNs, we were informed by staff that this was not always sufficient and they sometimes did not feel safe.
- The wards had a high use of regular agency staff, short-term agency staff and bank staff. On the day of the inspection the wards did not know who was going to be working on the mid shift until they walked onto the ward at 11am. This meant that the planning for the patient activity, including section 17 leave, appeared difficult as the wards were unaware of the skill mix and experience of the team on duty that day.
- We were told by the patients and the staff that there was always a qualified nurse on duty and present on the wards. However due to their level of responsibility and record keeping this meant that they were sometimes tied up in the office leaving one support worker in the communal areas of the wards until 11am.

# Acute wards for adults of working age and psychiatric intensive care units

- The wards utilised contracted agency staff to perform the primary nurse roles on the ward. This meant that every patient had an allocated nurse. When we looked at the care records we could see evidence that there were weekly one-to-ones between staff and patients taking place.
- Patients told us that there were not enough staff on the wards to support their section 17 leave. They told us that if there were more staff then they could have more leave. We were also told that patients' leave to visit their families had been cancelled due to lack of staff to escort them but the leave had been re-arranged and the patients had been informed. When we looked at the section 17 leave records we could see that people were leaving the ward to go into the community at least once a week if their risk rating and leave allowed.
- There were 2 RMN's working on each ward for the day shift and one per ward on night shift. There were four doctors covering the six wards.
- All new staff received a mandatory 3 week induction that included security, safeguarding, basic life support, infection control and MVA.
- Ward staff told us that when new agency staff came on to the ward they were given a verbal induction but it was not recorded so could not be verified.
- Mandatory training was refreshed annually.
- From June 2015 most training had been made available to staff as an e-learning module.

## Assessing and managing risk to patients and staff

- A risk assessment was completed on admission for all patients, but we found that this did not inform individually tailored care plans.
- We were told that individual risk management plans were created based on risks. We found that a patient on Edith Cavell ward had a note to say that he was a registered sex offender but this was not noted on the risk assessment.
- The wards used a risk assessment tool stored separately to the electronic record system called care notes. These were filled in on admission however, we found no recorded evidence of these being regularly updated. Helen Keller ward had the assessments for all patients completed on the first day of the inspection but very little recorded prior to the inspection. The risk rating given to each patient was referred to in the multidisciplinary meeting but there appeared to be no formal assessment of patients' risk and these were not routinely updated following incidents on the wards.
- On the acute wards there were blanket restrictions in place regarding patients access to a hot drink from the kitchen. Patients were required to wait until it was the allocated time to make a drink, staff stated that they would make a drink for a patient at their request between these times but members of the inspection team observed staff telling patients that they must wait until drink time. There were cold drinks machines on both wards but these appeared not to have any cups for the patients to use.
- Patients had access to their mobile phones but these were at allocated times every day, and not based on individual assessment. On Edith Cavell ward there was free access to the garden, however patients on Helen Keller ward had access to the garden only once an hour.
- Staff informed us that informal patients were able to leave at their request. Between Edith Cavell and Helen Keller wards and the front of the hospital there were five locked doors that staff had to open to let an informal patient out, this took a number of minutes and was dependant on staff availability. We witnessed an informal patient request to leave the ward after lunch who was told they had to wait until the cutlery count and medication round was completed. The nurse in charge informed the inspection team that medication could take around an hour. As a result informal patients were unable to leave the ward when they requested to.
- All the wards had clear procedures for observing patients. Staff informed us that observations were never affected by staffing levels.
- The nurses carrying out one-to-one nursing observations on all the wards were not receiving regular breaks from the observations. The shift planning records showed that staff were not routinely allocated a break. Some staff had carried out one-to-one observations for up to six hours. The hospital policy and National Institute for Health and Care Excellence (NICE) guidelines state that staff carrying out one-to-one observations should have breaks at least every two hours.

# Acute wards for adults of working age and psychiatric intensive care units

- The hospital policy stated that there should be a care plan with the observation sheets to inform staff of the risks and presentation of the patient and any interventions that may be needed, this was not present on any of the observation boards that we saw.
  - Staff were able to talk us through de-escalation principles. They were trained in management of violence and aggression in order to restrain patients if needed.
  - Rapid tranquilisation was used on the wards. Patients were administered medication through intramuscular injection and orally if needed. Following rapid tranquilisation, patients' physical observations were not routinely being recorded. The Partnerships in Care policy stated that patients should have their physical observations monitored four times an hour for the first hour and then half hourly thereafter until they were ambulatory. We heard from nursing staff that a patient in receipt of Clopixol Accuphase injection the previous day had no physical health monitoring conducted and the care notes we checked for this incident did not have physical observations recorded. A patient on Helen Keller Ward was given accuphase, diazepam and promethazine and was on one-to-one observations but we could find no physical observations had been taken. This was contrary to the Partnerships in Care policy and did not guarantee that medications were being safely administered. The staff were not using the physical observation form that they were required to use as stated in their policy.
  - We found that the route of administration of medication was not always recorded on the seclusion documentation. We also found that the EPR was not consistent with the seclusion record for example on 10 April 2015, 9.20 am acuphase 100mg and diazepam 10mg was administered but on the EPR no time is recorded when this medication was administered. On the same day a second medication was given IM promethadine but no time was recorded as to when this was administered on the EPR system.
  - There were 23 number of episodes of seclusion in acute and PICU from January 2015 to June 2015. These were highest on Helen Keller ward.
  - We found documentation in use for the recording of episodes of seclusion, in the form of three packs, 0-4 hours, 4-24 hours and ongoing 24 hours. From the records that we reviewed the reasons for seclusion were not clearly evidenced or were poorly evidenced. Also, on 10 of those records the recording of reasons for seclusion was minimal for example, "de-escalation failed", or, "no other option".
  - We could not evidence recent audits on the use of seclusion and seclusion documentation and practices.
  - The seclusion and long-term segregation areas were generally found to be in good condition, with en-suite facilities, TV facilities and remote controlled blinds on the windows and a clock available. There was also a call system for patients to talk to staff and these were in working order during this visit. Drinks were available for patients whilst in seclusion and cold finger food was provided. Pillows for use in seclusion were available, but staff needed to be aware of the location of the pillows and record when this facility was offered to patients.
  - There were 58 number of episodes of restraint. These were highest on Helen Keller ward
  - There were 10 incidents of prone restraint. There were highest on Helen Keller wards
  - The ward staff did not make direct safeguarding referrals. We asked staff members how they would make a safeguarding referral and they told us they refer to the safeguarding lead for the hospital and out of hours they would report to the duty manager. The staff we spoke with had a good understanding of what constituted a safeguarding matter. They informed us that they had a good relationship with the local authority and safeguarding referrals were always made quickly and appropriately.
  - Children were not allowed into the ward areas, staff had to facilitate visits from families in private rooms in the reception area of the hospital.
- ## Track record on safety
- There were no serious incidents recorded on the acute wards from October 2014 to June 2015.
  - All incidents were reported to the Care Quality Commission.
- ## Reporting incidents and learning from when things go wrong

# Acute wards for adults of working age and psychiatric intensive care units

- All the regular staff we spoke with felt confident in using the electronic incident reporting systems. However when there were predominantly agency staff on duty they were unable to access the electronic system and so there could be occasions when incidents might not be reported.
- We were told that information was discussed both at individual supervision level and at staff meetings when serious incidents occurred across the hospital. We were told the majority of information handed over was via email to individual people but we were unable to view any examples during the inspection.

## Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement



### Assessment of needs and planning of care

- We reviewed care records and found that some patients had generic care plans. Care plans were not up to date with information that reflected their care, for example, observation levels on updated care plans had not been changed from one-to-one to 15 minute observations. We found that a patient who had a particular behavioural issue which was reported to be her primary need had no care plan created to help her and staff manage her illness.
- We found one care plan regarding leave arrangements had not been updated to reflect a recent incident where the patient had been absent without leave and indicated that the patient still had leave despite the fact it had been cancelled by the responsible clinician.
- Care plans on Edith Cavell ward were not patient centred and were the same for many of the patients. This did not provide patients with a service that was tailored to meet their individual needs.
- The care plans were not written in plain English and the inspection team were unsure of the meaning of the wording in the generic management of violence and aggression care plan that appeared on many of the patient records. The care plan stated “general services

techniques and follow hierarchical responses to violence and aggression”, we were not clear on the meaning of this so could not be assured that agency staff and patients would understand this either.

- The pharmacist inspectors reviewed all the prescription charts for patients detained at the hospital. For one patient the T3 certificate of second opinion was not with the prescription chart and therefore it was not possible for ward staff to check that medicines had been prescribed in accordance with this form before they administered. For two patients medicines had been prescribed and administered which were not in accordance with the T3 form.
- Physical examination of patients were conducted on admission. We reviewed a number of clinical records across the wards and found that despite the T2 certificates of consent to treatment stating that an electrocardiogram (ECG) should be conducted every three months for patients prescribed the antipsychotic medication clozapine there was no record of these taking place.

### Best practice in treatment and care

- Neither of the acute wards were able to offer patients psychological therapies because they were not commissioned to do so. We were told by nursing staff that the duty to provide a therapeutic input was on the relationship between the nurse and the patient. When reviewing 10 sets of notes on Edith Cavell ward we found that eight of them had no recorded one-to-one time with the patients.
- Patients had access to the visiting GP when required. The wards had access to a practice nurse (who had left the day before the inspection). The patients had no formal health management plan, such as a “health action plan” or “health passport” to facilitate smooth information sharing with the local secondary health care services.
- The service had no access to a dietitian however the hospital director reported that they had recently recruited a dietitian and were awaiting a start date, however there was a qualified nutritionist in post during the inspection.

# Acute wards for adults of working age and psychiatric intensive care units

- All wards had a medicines management daily monitoring book to check prescribed medication had been given and correct codes were used for omitted medications. However, on Edith Cavell ward this had not been completed for 10 days in July.
- The hospital used the health of the nation outcome scales to assess and record severity and outcome ratings.

## **Skilled staff to deliver care**

- Staff received a full induction including mandatory training at the start of their employment. Agency staff received training in the hospital safety processes but only received a verbal induction when starting at the hospital.
- Staff informed us that there were very little development opportunities however the hospital informed us that specialist training was provided.
- We saw evidence that team meetings took place and staff confirmed to us they had attended team meetings but they were not set at regular intervals on all wards.
- Staff received line management and appraisals but there had been a very high turnover of staff and high vacancy rates which had disrupted line management and appraisal schedules. Therefore line management arrangements were inconsistent across wards. Staff told us that access to clinical supervision was limited.
- On Edith Cavell ward 40% of staff had received an appraisal in the previous 12 months. On Helen Keller ward 87% of staff had received an appraisal in the previous 12 months.
- The staff we spoke with told us that performance issues were dealt with promptly via the line management structure.

## **Multi-disciplinary and inter-agency team work**

- The wards had multidisciplinary teams including occupational therapy but the acute wards did not have psychology input. Patients were reviewed weekly in a multidisciplinary meeting.
- Staff handed over each shift referring to a handover sheet with a narrative of each patient in order to inform staff of the needs, history and risks of a patient. The

sheet also informed staff of the observation level and care plans. On one sheet we saw that there was information about the wrong patient in the section that gave date of admission, plan and risk information.

## **Adherence to the MHA and the MHA Code of Practice**

- A Mental Health Act assessment had taken place for a patient on Edith Cavell ward on 14 July in the evening but on 16 July staff were still unsure whether he had been placed on a section yet. We found no note made in the patients' notes by medical staff and there had been no communication between the approved mental health practitioner and the ward nurses following the assessment. The patient had been placed on a section on 14 July but ward staff did not know and could not tell us how patients rights had been protected during this time.
- Staff we spoke with had a good working knowledge of the Mental Health Act and the relevant sections relating to the patient group.
- We saw medication cards had copies of consent to treatment forms appropriately attached.
- We saw good evidence of a full and thorough system for checking that patients' rights were regularly discussed with the patient group.
- A Mental Health Act administrator was based within the hospital and staff felt confident they could approach them with any issues relating to the Mental Health Act.
- All detention paperwork was held electronically and could be accessed freely across the site.
- Patients had access to generic advocacy.

## **Good practice in applying the MCA**

- The staff we spoke with did not have a good awareness of the Mental Capacity Act and its guiding principles. One staff member told us they were not aware of the Act and another described the Mental Capacity Act as being predominantly to do with managing patient finances. We saw on the organisational training matrix that all new staff receive fifteen minutes training on mental health act awareness during their induction and annual mandatory mental health code of practice training however staff told us they did not have regular training in the Mental Capacity Act.

# Acute wards for adults of working age and psychiatric intensive care units

- The staff did not refer to any policy relating to the implementation of the Mental Capacity Act at the Dene, however saw that the Dene had a Mental Capacity Act and Deprivation of Liberty Safeguards policy that was dated May 2015
- We did not observe any capacity related documentation or discussion evidenced in any of the care and treatment records we observed during the inspection.

## Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good



### Kindness, dignity, respect and support

- We saw multiple examples of positive and appropriate attitudes towards by staff during the inspection. Patients told us that they liked the staff and that they were better than the staff in their previous hospitals. Patients told us that the staff treated them fairly and all comments were positive.
- The comment cards we received also reported that the staff were caring and attentive.
- It was clear from our observations that there was good rapport between the patients and staff. Staff members recognised and understood the individual needs of the patients.
- We observed two care programme approach meetings, staff were very caring towards the patients and showed an excellent understanding and knowledge of that patient. The patient was allowed to have a voice and their comments were added to the care plan during the meeting.
- Staff were observed to be caring and respectful of the patients. However, 8 out of 10 patients on the acute wards had no record of one-to-one sessions with their named nurse.

### The involvement of people in the care they receive

- The wards did not have an admission process into the ward environment. However staff told us they would show the patients around the ward when they were

admitted and support them to attend the morning meeting to introduce themselves. Patients on both wards informed us that staff had given them a lot of information on admission.

- There was a policy for ensuring patients property should be documented upon admission however this process was not being followed consistently. Patients informed us that they did not feel that their property was always safe
- We found it was regularly recorded that the patients were offered a copy of their care plan but chose to keep it in the office on the ward. Patients told us they could request a copy of their care plan if they wanted to look at it. There was little evidence of patient involvement in the care plans and the care plans were not formulated in an easy read or individualised format.
- There was information relating to the generic advocate that visited the ward on the notice board and patients could all identify who the advocate was and when they visited the ward.
- The patients had regular daily meetings and a weekly longer community meeting on the wards.

## Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Requires improvement



### Access and discharge

- Average bed occupancy for Helen Keller ward between December 2014 and June 2015 was 100% whilst the average bed occupancy for Edith Cavell ward in the same period was 78%.
- Staff we spoke with informed us that it was often difficult to discharge patients when they were ready to leave because there were issues around care co-ordinators constantly changing or being too far away to have regular involvement with the patient.
- There were four delayed discharges reported by The Dene on the acute wards between December 2014 and June 2015.

# Acute wards for adults of working age and psychiatric intensive care units

## The facilities promote recovery, comfort, dignity and confidentiality

- The wards had quiet areas, activity rooms and a lounge, the lounge was situated in a corner of the dining room and was not partitioned off.
- When we visited Edith Cavell ward we found the quiet room was locked and patients were therefore not able to access a quiet space outside of their bedrooms.
- All wards had unlimited access to a private phone.
- Patients on Edith Cavell ward had unlimited garden access. However, patients on Helen Keller ward were only able to facilitate garden access for a cigarette once an hour.
- We received mixed reports from the patients about the food. Some patients we spoke with reported feeling happy with the quality of the food but commented that the portion sizes were not big enough.
- All wards had restricted access to hot drinks. Staff stated that hot drinks were made at certain times of the day but if patients asked then staff would make them a drink. Patients on the wards informed us that they were often denied hot drinks at their request outside of the allotted time.
- The patients' bedrooms did not appear to be personalised but staff told us that they were able to personalise rooms if the patients wished.
- Patients had a locked store which was accessible with staff.
- There were activities on the wards but patients informed us that they were often unable to do activities due to their ward being short staffed and at weekends there were no facilitated activities so patients were left feeling bored.

## Meeting the needs of all people who use the service

- The wards that were situated on the ground floor of the hospital that were over one level allowed for good disabled access to the ward, with one room on each ward that was adapted for disabled needs.

- We found no information in different languages on the wards for those requiring it and staff were unable to tell us if this could be obtained if required. There was access to an interpreter if needed which needed to be arranged with the administrative staff.
- There were notice boards on the wards containing information about access to an advocate, how to complain, activity time tables and community meeting minutes.
- We were informed by staff that the kitchen was able to meet dietary requirements for religious and ethnic groups.
- The wards had access to a multi faith room which was situated off the wards. Patients were able to access this room with staff support.

## Listening to and learning from concerns and complaints

- There were 34 complaints raised by patients, friends and carers throughout the hospital between September 2014 and May 2015. Of these 32 complaints were resolved within a month of them being raised.
- Patients were provided with information on how to complain. Staff were aware of the complaints policy and were able to support patients to make formal complaints. Each ward had an informal complaints book which was used to try and resolve any issues before they escalated, staff and patients were able to sign this off together when they were happy with the outcome of complaints.
- Feedback from complaints investigations was done in staff meetings, these were recorded in minutes and distributed to the ward staff.

## Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement



## Vision and values

- Only one member of staff on the acute wards was able to say what the organisation's values were.

# Acute wards for adults of working age and psychiatric intensive care units

- The managers of the wards told us they felt able to talk about their opinion to the senior managers of the hospital and they were able to raise concerns.
- Staff felt connected with the hospital director and told us she visited the wards. They described the senior management of the hospital as being approachable.

## Good governance







- We saw the hospital's clinical governance annual plan for 2014/15 which indicated that quarterly objectives were agreed by the senior management in the hospital. The hospital tracked its performance against the objectives on a quarterly basis.
- The hospital used a quality dashboard called "Ward to Board" to track monthly performance against the five CQC domains of safe, effective, caring, responsive and well-led.
- There was no evidence that the staff on the ward were formally inputting into any key performance indicator process.
- There were insufficient systems in place to ensure care plans were fully updated and patient-focused.
- There were insufficient systems in place to ensure risk assessments were updated following incidents.
- There was not a system in place to ensure that all staff received regular clinical supervision.
- There was not a system in place to ensure that all staff received regular appraisals.

- Staff told us that incidents were recorded when there were full time staff or contracted agency staff on duty.
- Most of the ward managers we spoke with were very new in their roles or were acting ward managers. Their level of knowledge about managing the wards and line management responsibilities was therefore quite limited.
- The staff had a dashboard that informed them of key dates for patients such as section 132 rights, care plan updates and physical health assessment dates. This made sure staff were able to make sure that tasks were completed in a timely manner, however, we found that care plan updates did not necessarily reflect the change in needs of the patients and appeared only to have the dates changed.

## Leadership, morale and staff engagement

- Staff reported that they felt able to bring issues to the attention of the senior management team.
- Staff members told us that they were stressed by the lack of permanent staff and patients were not able to leave the wards due to staffing levels. Staff stated because they felt so stretched, there was not enough time to do tasks necessary for patient care.
- Staff stated that they felt burnt out due to the lack of support offered. Staff felt that the lack of therapy on the ward meant that therapeutic needs were not being assessed, staff were not able to have one-to-one time with their patients because there was only time to manage essential needs of each patient and staff were not able to offer more than this.

# Forensic inpatient/secure wards

Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well-led	Requires improvement	
Overall	Requires improvement	

## Information about the service

The Dene is an independent hospital run by Partnerships in Care, based in West Sussex. It takes referrals from anywhere within the country.

The Dene is registered under the Health and Social Care Act 2008 to provide the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury; and diagnostic and screening procedures.

The Dene has a registered manager.

The Dene provides medium and low secure services for females and an inpatient service for women with high dependency needs (a high dependency unit). They also provide an acute service for men and at the time of our inspection had a temporary ward for males with learning disabilities in order to take patients from two recently closed hospitals in the area.

At the time of our inspection there were six wards in use:

Amy Johnson ward - a 12 bed female medium secure ward;

Elizabeth Anderson ward - a 16 bed female medium secure ward;

Michael Shepherd ward - a 16 bed female low secure ward;

Edith Cavell ward - an 18 bed male acute mental health ward;

Helen Keller ward - a 12 bed female high dependency acute mental health ward;

Wendy Orr ward - an eight bed temporary male ward for people with learning disabilities.

The Dene has been inspected three times previously by CQC, in November 2012, April 2013 and October 2013. At the last inspection in October 2013 the location met all essential standards inspected.

At the time of our inspection, there were 5 patients temporary on Wendy Orr ward. We inspected this ward but have not reported on this as it was closed two weeks after the inspection.

# Forensic inpatient/secure wards

## Summary of findings

We rated The Dene as **requires improvement** because:

- There was a high level of vacancies on the wards which resulted in agency staff being used to cover many shifts and caused an inconsistency in patient care. The staff shortages led to increased pressure on staff, it was difficult for ward staff to plan patient activities each day and some staff were not getting regular breaks. The staff shortages also meant that not all staff received regular supervision or appraisals because there were vacancies in line-manager posts and many of the ward managers were very new in post.
- Risk assessments were not fully updated. There were insufficient systems in place to ensure risk assessments were updated following incidents.
- Care plans were not always fully updated and patient centred. There were insufficient systems in place to ensure care plans were fully updated and patient-focused.
- Recording of physical healthcare checks were inconsistent.
- There were blanket restrictions in place on all wards.
- Patients who used wheelchairs had to use a different outside space to other patients because the courtyard was not accessible.

However:

- Patients told us that the staff treated them fairly and all comments were positive.
- There was good rapport between the patients and the staff. Staff members recognised and understood the individual needs of the patients.
- The hospital had governance plans and quality dashboards in place to set objectives and monitor performance.
- Staff felt able to raise issues to the senior management team.

## Are forensic inpatient/secure wards safe?

Requires improvement



### Safe and clean environment

- There were not clear lines of sight for observing patients. There were many blind spots across the wards. Convex mirrors were in place in areas on the ward to assist staff to observe the entire ward, however we still observed some blind spots along bedroom corridors. Staff told us they regularly checked corridors and would discretely follow a patient if they moved out of view.
- Ligature cutters were stored safely on all wards and staff told us where to get them from if required.
- All bedrooms had en suite bathrooms. Wards were single sex and all patients had their own rooms.
- Amy Johnson wards had a medication dispensing room, accessed by staff through the office. Patients did not access this room as it was purely for the storing of medication so had to wait in the corridor for their medication to be dispensed.
- On all three wards medicines were stored securely. Records were made of medicine refrigerator and room temperatures on a daily basis and these were all within the expected temperature ranges.
- The contents of the emergency medicine bags were checked regularly by hospital staff; all contents were found to be in date.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of Drugs Act 1971 and its associated regulations. The standard operating procedures for controlled drugs had been reviewed and updated in 2015. Incidents involving controlled drugs were reported via the incident reporting system, these were investigated by the Accountable Officer for controlled drugs and records made of the actions taken.
- A pharmacy service was provided by an external contractor. The contracted pharmacist conducted a

# Forensic inpatient/secure wards

missed dose audit on a monthly basis, which looked at three prescription charts from each ward. The hospital did not conduct regular audits of out of stock medicines.

- The CQC pharmacist reviewed all the prescription charts within the hospital. At the time of inspection two patients on Michael Shephard ward had not received their medicines as prescribed as they were not in stock for a number of days.
- There was inconsistent recording of the allergy status of patients.
- Seclusion rooms were not situated on all wards. Two of the seclusion rooms were situated up a flight of stairs on the first floor. Staff reported that the upstairs seclusion rooms were better designed and more appropriate to the needs of the patients and they were therefore the ones that were prioritised for use. Staff on some wards were therefore put in a situation where they needed to restrain patients and escort them through several doors and up and down stairs in order to access seclusion. The hospital have considered the best way to manage any MVA interventions in the best and safest way for both staff and patients. All clinical staff who are MVA trained cover movement s up and down stairs in their annual MVA training.
- During our inspection Amy Johnson ward was having the bedrooms and corridors painted.
- Patients and staff told us that the patients did not have keys for their bedrooms or for the lockable space in their bedrooms, this meant that if patients did not ask staff to lock their room other patients could access their bedrooms. Patients told us they would like to have keys for their rooms but they were not concerned about their possessions going missing.
- Risk assessments of the environment were undertaken each shift by the nurse in charge of security, this nurse was also in charge of knowing the whereabouts of each patient and staff member and keeping a log of movements on and off the ward.
- The ward had a weekly security folder which gathered together all the processes for checking the

environmental and procedural security of the ward. Staff told us they found the security folder complicated and difficult to navigate due to the large number of pages per day that needed completing.

- There were call alarms for staff and patients, staff were issued with personal alarms prior to starting the shift. Identified staff members were allocated as first responders to incidents in the hospital.
- There were handwashing signs in appropriate places around the wards.
- The cleaning schedules showed that regular daily cleaning was being done and the schedules indicated this was being well audited by the domestic manager.
- Staff told us they were not involved in any environmental risk audits or risk assessments and had not seen any since working on the wards.

## Safe staffing

- The data provided by the hospital prior to the inspection stated that there was a 46% vacancy rate for qualified nurses on the secure wards (10.5 vacancies out of a total of 23 whole time equivalent positions). There was a vacancy rate of 20% for nursing assistants (8 vacancies out of 40 whole time equivalent positions.)
- The wards had a high use of regular agency staff, short-term agency staff and bank staff. On the day of the inspection the wards did not know who was going to be working on the mid shift until they walked onto the ward at 11am. This meant that the planning for the patient activity, including section 17 leave appeared difficult as the wards were unaware of the skill mix and experience of the team on duty that day.
- Ward staff told us that that when new agency staff came on to the ward they were given a verbal induction but it was not recorded so could not be verified.
- The wards used contracted agency staff to perform the primary nurse roles on the ward. This meant that every patient had an allocated nurse. When we looked at the care records we could see evidence that there were one-to-ones between staff and patients taking place but they were not recorded on a weekly basis.
- All new staff received a mandatory 3 week induction that included security, safeguarding, basic life support, infection control and MVA.

# Forensic inpatient/secure wards

- Ward staff told us that when new agency staff came on to the ward they were given a verbal induction but it was not recorded so could not be verified.
- Mandatory training was refreshed annually.
- From June 2015 most training had been made available to staff as an e-learning module.
- Staff were able to talk us through de-escalation principles. They were trained in management of violence and aggression in order to restrain patients if needed.
- During our inspection there were no patients subject to seclusion or long term segregation. There had been 30 episodes of seclusion in forensic secure units from January 2015 to June 2015. These were highest on Elizabeth Anderson ward. There were 188 episodes of restraint. These were highest on Elizabeth Anderson ward. There were 25 incidents of prone restraints. These were highest on Elizabeth Anderson ward.

## Assessing and managing risk to patients and staff

- The wards used a risk assessment tool which was stored separately to the electronic record system called care notes. These were filled in on admission however, we found no recorded evidence of these being regularly updated according to patient need. The risk rating given to each patient was referred to in the multidisciplinary meeting but there appeared to be no formal assessment of patients' risk. These were not routinely updated following incidents on the wards.
- The patients in the secure wards had set times to access the garden which resulted in patients only being able to go outside four times a day.
- The wards had clear procedures for observing patients and there was a number of patients on the wards on one-to-one nursing observation levels. Other observation levels ranged from 15 minute observations to hourly observations dependant on risk.
- The nurses carrying out one-to-one nursing observations were not receiving regular breaks from the observations. The shift planning records showed that staff were not routinely allocated a break. Some staff had carried out one-to-one observations for up to six hours. The hospital policy and National Institute for Health and Care Excellence (NICE) guidelines state that staff carrying out one-to-one observations should have breaks at least every two hours.
- The hospital policy stated that there should be a care plan with the observation sheets to inform staff of the risks and presentation of the patient and any interventions that may be needed, this was not present on any of the observation boards for the one-to-ones and there was no one-to-one care plan recorded on the electronic record system for any of the patients.
- We found documentation in use for the recording of episodes of seclusion, in the form of three packs, 0-4 hours, 4-24 hours and ongoing 24 hours. From the records that we reviewed the reasons for seclusion were not clearly evidenced or were poorly evidenced. Also, on 10 of those records the recording of reasons for seclusion was minimal for example, "de-escalation failed", or, "no other option".
- The ward staff did not make direct safeguarding referrals. We asked staff members how they would make a safeguarding referral and they told us they refer to the safeguarding lead for the hospital and out of hours they would report to the duty manager. The staff we spoke with had a good understanding of what constituted a safeguarding matter. They informed us that they had a good relationship with the local authority and safeguarding referrals were always made quickly and appropriately.
- Children were not allowed into the ward areas, staff had to facilitate visits from families in private rooms the reception area of the hospital.

## Track record on safety

- There were two serious incidents in the secure services between October 2014 and June 2015. Both incidents had been investigated by the hospital.

## Reporting incidents and learning from when things go wrong

- All the regular staff we spoke with felt confident in using the electronic incident reporting systems. However

# Forensic inpatient/secure wards

when there were predominantly agency staff on duty they were unable to access the electronic system and so there could be occasions when incidents were not reported.

- We were told that information was discussed both at individual supervision level and at staff meetings when serious incidents occurred across the hospital. We were told the majority of information handed over was via email to individual people, we were unable to see evidence of de briefings being carried out or lessons learnt after incidents during our inspection.

## Are forensic inpatient/secure wards effective?

(for example, treatment is effective)

Requires improvement



### Assessment of needs and planning of care

- We reviewed 35 care records and found that patients had generic care plans. Patients' care plans had exactly the same wording and only names were changed from patient to patient. We were told that individual risk management plans were created based on risks. Care plans were not up to date with information that reflected their care, for example, observation levels on updated care plans had not been changed from one-to-one to 15 minute observations. One of the care plans directed "continue psychological work around index offence" however offence specific work was not being provided by the treating team.
- The care plans did not use plain English and the inspection team were unsure of the meaning of the wording in the generic management of violence and aggression care plan that appeared on many of the patient records. The care plan stated "general services techniques and follow hierarchical responses to violence and aggression", we were not clear on the meaning of this so could not be assured that agency staff and patients would understand this either.

### Best practice in treatment and care

- Patients had access to the visiting GP when required. The wards had access to a practice nurse (who had left the day before the inspection). The patients had no

formal health management plan, such as a "health action plan" or "health passport" to facilitate smooth information sharing with the local secondary health care services.

- The service had no access to a dietitian however the Hospital Director reported that they had recently recruited a dietitian and were awaiting a start date, however there was a qualified nutritionalist in post during our inspection.
- All wards had a medicines management daily monitoring book to check prescribed medication had been given and correct codes were used for omitted medications.
- The hospital used the Health of the Nation Outcome Scales (HoNOS) to assess and record severity and outcome ratings. The hospital's management data showed monthly figures for improvement versus deterioration in secure services measured by HoNOS. Between November 2014 and May 2015 an average of 41 out of 46 patients had been recorded as maintaining or improving their mental health.

### Skilled staff to deliver care

- The wards had multidisciplinary teams including occupational therapists. The hospital's data showed that on the secure wards between March and May 2015, 97% of patients had accessed psychological and talking therapies, including the extended community meetings.
- Staff received a full induction including mandatory training at the start of their employment. Agency staff received training in the hospital safety processes but were not given a specific hospital induction.
- There were 2 RMN's working on each ward for the day shift and one per ward on night shift. There were four doctors covering the six wards
- We saw evidence that team meetings took place and staff confirmed to us they had attended team meetings but they were not set at regular intervals on all wards.
- Staff received line management and appraisals but there had been a very high turnover of staff and high vacancy rates which had disrupted line management and appraisal schedules. Therefore line management

# Forensic inpatient/secure wards

arrangements were inconsistent across wards. Staff told us that access to clinical supervision was limited. Supervision and appraisal rates were in line with Partnerships In Care policy across all wards.

- The percentage of staff who had received an appraisal in the previous 12 months varied across the secure wards. On Elizabeth Anderson ward 93% of staff had received an appraisal in the previous 12 months; on Michael Shepherd ward the figure was 78% and on Amy Johnson ward it was 69%.
- The staff we spoke with told us that performance issues were dealt with promptly via the line management structure.

## Multi-disciplinary and inter-agency team work

- We observed two multidisciplinary meetings during the inspection. This meeting was attended by the consultant psychiatrist, nurse and an occupational therapist. The meeting was set with the doctor at the computer and notes were completed through the meeting. The needs of the patient were considered and patient choice was respected, changes of medication were agreed mutually and it was clear that decisions were made in conjunction with the patient. However, due to the doctor being at the computer it felt that the attention was not always on the patient but on documentation.
- Staff handed over each shift referring to a handover sheet with a narrative of each patient in order to inform staff of the needs, history and risks of a patient. The sheet also informed staff of the observation level and care plans.

## Adherence to the MHA and the MHA Code of Practice

- Staff we spoke with had a good working knowledge of the Mental Health Act and the relevant sections relating to the patient group.
- We saw medication cards had copies of consent to treatment forms appropriately attached.
- We saw good evidence of a full and thorough system for checking that patients' rights were regularly discussed with the patient group.
- A Mental Health Act administrator was based within the hospital and staff felt confident they could approach them with any issues relating to the Mental Health Act.

- All detention paperwork was held electronically and could be accessed freely across the site.
- Patients had access to generic advocacy.

## Good practice in applying the MCA

- On all the wards, the staff we spoke with did not have a good awareness of the Mental Capacity Act and its guiding principles. One staff member told us they were not aware of the Act and another described the Mental Capacity Act as being predominantly to do with managing patient finances. The staff told us they did not have regular training in the Mental Capacity Act, however the organisational training matrix shows that Mental Health training is completed annually.
- The staff did not refer to any policy relating to the implementation of the Mental Capacity Act at the Dene.
- We did not observe any capacity related documentation or discussion evidenced in any of the care and treatment records we observed during the inspection.

## Are forensic inpatient/secure wards caring?

Good



## Kindness, dignity, respect and support

- We saw multiple examples of positive and appropriate attitudes towards by staff during the inspection. Patients told us that they liked the staff and that they were better than the staff in their previous hospitals. Patients told us that the staff treated them fairly and all comments were positive.
- The comment cards we received also reported that the staff were caring and attentive.
- It was clear from our observations that there was good rapport between the patients and staff. Staff members recognised and understood the individual needs of the patients.
- We observed a ward lockdown and search being carried out on Michael Shephard ward, all patients and their belongings were treated respectfully and patients had the procedure explained to them. Patients were allowed to watch their rooms being searched if they wanted. One

# Forensic inpatient/secure wards

patient become very distressed at the start of the search because she did not want her possessions to be moved. Staff dealt with her in a very kind and supportive manner and allowed her to have her room searched first. We saw all rooms effectively searched causing very little disruption to patients and returned to how they were found upon completion of the search.

- We observed two care programme approach meetings for patients on Amy Johnson and Elizabeth Anderson wards, staff were very caring towards the patients and showed an excellent understanding and knowledge of that patient. The patient was allowed to have a voice and their comments were added to the care plan during the meeting.
- Staff were observed to be caring and respectful of the patients.

## The involvement of people in the care they receive

- The wards did not have an admission process into the ward environment. However staff told us they would show the patients around the ward when they were admitted and support them to attend the morning meeting to introduce themselves.
- There was a policy for ensuring patients property should be documented upon admission however this process was not being followed consistently. This meant that patients' property was not always safely protected.
- We found it was regularly recorded that the patients were offered a copy of their care plan but chose to keep it in the office on the ward. Patients told us they could request a copy of their care plan if they wanted to look at it. There was little evidence of patient involvement in the care plans and the care plans were not formulated in an easy read or individualised format.
- There was information relating to the generic advocate that visited the ward on the notice board and patients could all identify who the advocate was and when they visited the ward.
- The patients had regular daily meetings and a weekly longer community meeting on the wards. We saw an extended meeting being held on one ward due to some issues being identified the previous day at a patient's

multidisciplinary team meeting around bullying which dealt with the serious issue with compassion and involved the patients in identifying how everyone should be treated with respect and kindness.

## Are forensic inpatient/secure wards responsive to people's needs? (for example, to feedback?)

Requires improvement



## Access and discharge

- Average bed occupancy for secure services between December 2014 and June 2015 was 84%.
- Staff we spoke with informed us that it was often difficult to discharge patients when they were ready to leave because there were issues around care co-ordinators out of areas constantly changing or being too far away to have regular involvement with the patient.
- There were three delayed discharges reported by The Dene on the secure wards between December 2014 and June 2015.

## The facilities promote recovery, comfort, dignity and confidentiality

- The wards had quiet areas, activity rooms and a lounge, the lounge was situated in a corner of the dining room and was not partitioned off.
- All wards had unlimited access to a private phone.
- The secure wards had allotted courtyard access which resulted in patients having half an hour outside four times a day. Patients said that if they wanted fresh air outside of the allotted cigarette time they were often denied.
- We received mixed reports from the patients about the food. Some patients we spoke with reported feeling happy with the quality of the food but commented that the portion sizes were not big enough.
- Patients had a locked store which was accessible with staff.

# Forensic inpatient/secure wards

- There were activities on the wards but patients informed us that they were often unable to do activities due to their wards being short staffed or that at weekends there were no facilitated activities so patients were left feeling bored.

## Meeting the needs of all people who use the service

- The three secure wards on the first floor had adapted doorways and bathrooms in order to accommodate wheelchair users.
- Patients who used wheelchairs who were situated on the first floor wards were unable to go into the courtyard for outside space. The courtyard was unable to accommodate wheelchairs so patients who used wheelchairs had to be taken into a separate outside area. Patients told us that this made them feel isolated from the rest of the ward.
- We saw evacuation procedures developed for the patients in wheelchairs on the first floor as they were unable to access the stairwells in the event of a fire.
- We found no information in different languages on the wards for those requiring it. Staff told us that there was access to an interpreter if needed which had to be arranged with the administrative staff.
- There were notice boards on the wards containing information about access to an advocate, how to complain, activity time tables and community meeting minutes.
- We were informed by staff that the kitchen was able to meet dietary requirements for religious and ethnic groups.
- The wards had access to a multi faith room which was situated off the wards. Patients were able to access this room with staff support.

## Listening to and learning from concerns and complaints

- There were 34 complaints raised by patients, friends and carers throughout the hospital between September 2014 and May 2015. Of these 32 complaints were resolved within a month of them being raised.
- Patients were provided with information on how to complain. Staff were aware of the complaints policy and were able to support patients to make formal

complaints. Each ward had an informal complaints book which was used to try and resolve any issues before they escalated, staff and patients were able to sign this off together when they were happy with the outcome of complaints.

- Feedback from complaints investigations was done in staff meetings, these were recorded in minutes and distributed to the ward staff.

## Are forensic inpatient/secure wards well-led?

Requires improvement



## Vision and values

- The managers of the wards told us they felt able to talk about their opinion to the senior managers of the hospital and they were able to raise concerns.
- Staff felt connected with the hospital director and told us she visited the wards. They described the senior management of the hospital as being approachable.

## Good governance

- We saw the hospital's clinical governance annual plan for 2014/15 which indicated that quarterly objectives were agreed by the senior management in the hospital. The hospital tracked its performance against the objectives on a quarterly basis.
- The hospital used a quality dashboard called "Ward to Board" to track monthly performance against the five CQC domains of safe, effective, caring, responsive and well-led.
- There was no evidence that the staff on the ward were formally inputting into any key performance indicator process.
- There were insufficient systems in place to ensure care plans were fully updated and patient-focused.
- There were insufficient systems in place to ensure risk assessments were updated following incidents.
- There was not a system in place to ensure that all staff received regular clinical supervision.

# Forensic inpatient/secure wards

- Most of the ward managers we spoke with were very new in their roles or were acting ward managers. Their level of knowledge about managing the wards and line management responsibilities was therefore quite limited.
- The staff had a dashboard that informed them of key dates for patients such as section 132 rights, care plan updates and physical health assessment dates. This made sure staff were able to make sure that tasks were completed in a timely manner, however, we found that care plan updates did not necessarily reflect the change in needs of the patients and appeared only to have the dates changed.

## **Leadership, morale and staff engagement**

- Staff reported that they felt able to bring issues to the attention of the senior management team.
- Staff members told us that they were stressed by the lack of permanent staff and patients were not able to leave the wards due to staffing levels. Staff stated that things got missed because they felt so stretched and there was not enough time to do tasks for patient care.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the hospital **MUST** take to improve

- The hospital must continue to prioritise recruitment in order to reduce the vacancy rate in nursing staff to ensure a reduction in the use of agency staff and consistency in patient care.
- The hospital must ensure risk assessments are fully updated.
- The hospital must ensure physical healthcare checks are carried out as required and fully recorded.
- The hospital must ensure that care plans are fully updated and patient centred.
- The hospital must ensure that agency staff receive appropriate induction training.
- The hospital must ensure that staff receive regular clinical supervision and appraisals.
- The hospital must ensure that blanket restrictions are reviewed to ensure restrictions are only in place in response to identified patient risk.
- The hospital must ensure robust governance processes are in place to ensure the wards operated in line with the providers policies and procedures.
- The hospital should ensure that patients who use wheelchairs can access the outside space with other patients.
- The hospital should ensure areas are appropriately decorated including Edith Cavell and Helen Keller wards.
- The hospital should ensure that patients have access to keys for their rooms.
- The hospital should review the security folder to ensure it is easy for staff to use.
- The hospital should ensure there are updated records on what training staff have completed so that future training can be arranged.
- The hospital should ensure that informal patients can leave the ward when needed.
- The hospital should carry out an audit of seclusion to ensure this takes place in line with policies and procedures.
- The hospital should ensure regular team meetings take place.
- The hospital should link with local commissioners to ensure all detained patients have access to an independent mental health advocate.

### Action the hospital **SHOULD** take to improve

- The hospital should review the location of and use of seclusion facilities to ensure patients can be taken to the seclusion rooms safely.
- The hospital should ensure that patients have access to planned activities at weekends.
- The hospital should ensure that written information is available to patients in a number of different languages as required.
- The hospital should ensure arrangements are in place to support patients to safely store their possessions.
- The hospital should ensure all patients have a record of their allergies on their records and medication charts.
- The hospital should support patients to have a plan to manage their physical health.
- The hospital should ensure it has plans to support staff and improve morale.

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing  <b>How the regulation was not being met:</b>  There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet patients' care and treatment needs.  High numbers of agency staff were employed on the wards who were not fully trained and experienced in the hospital policies, procedures and processes. This meant that patient activities, section 17 leave and one-to-one time between patients and nursing staff could not be facilitated as planned.  This was a breach of regulation 18 (1)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing  <b>How the regulation was not being met:</b>  Staff did not receive the support, training, supervision and appraisals that are necessary for them to carry out their role and responsibilities.  Agency staff did not receive an appropriate induction to the hospital.  Staff did not receive regular clinical supervision or appraisals.

This section is primarily information for the provider

## Requirement notices

This was a breach of 18(1)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

**How the regulation was not being met:**

Patients and others were not protected against the risks associated with unsafe care and treatment.

Patients' risk assessments were not updated regularly in response to incidents.

Patients' physical healthcare checks were not carried out as planned or indicated by guidelines for medication or physical health conditions.

Patients' physical healthcare checks were not fully recorded.

This was a breach of regulation 12 (2)(a)(b)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

**How the regulation was not being met:**

The provider did not ensure that patients received care or treatment personalised specifically for them.

This section is primarily information for the provider

## Requirement notices

Care plans were not personalised and not fully updated to reflect changes in patients' needs.

There were blanket restrictions in place on the wards regarding outside garden access and access to hot drinks.

This was a breach of regulation 9(1)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**How the regulation was not being met:**

The provider did not have effective governance systems and processes in place to ensure they assessed, monitored and improved the quality and safety of the services provided.

The hospital did not have systems in place to ensure staff received regular supervision and appraisals.

The hospital did not have systems in place to ensure care plans were fully updated or recorded.

The hospital did not have systems in place to ensure risk assessments were updated following incidents.

This was a breach of regulation 17(1)