The Dene

Quality Report

Gatehouse Lane
Goddards Green
Hassocks
West Sussex
BN6 9LE
Tel: 0800 218 2398
Website: www.partnershipsincare.co.uk

Date of inspection visit: 26, 27 January 2016
Date of publication: 04/05/2016

This report describes our judgement of the quality of care at this location. 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

Overall summary

This inspection was a focussed inspection to follow up concerns we had received in relation to the physical healthcare provided to patients.

Our findings were that:

- Staff were not trained to manage and deliver many aspects of patients physical health needs and this care was not delivered in accordance with national guidance. Staff did not escalate concerns about their inability to meet patient needs.
- There was a lack of appropriate dressings and patients were at risk of cross contamination from poor wound management.
- The provider failed to ensure that there was learning from their own investigations following a serious event.
- There were high levels of agency staff employed who did not have the required training or expertise in managing chronic physical health conditions.their needs.

However:

- All the wards in the hospital were single gender which meant that the provider complied with government guidance in respect of same sex accommodation.
- The resuscitation equipment was checked daily on each ward.

Summary of findings

Contents

Summary of this inspection

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 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. There is a registered manager in post to oversee the operation of the service.

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 an inpatient service for women with high dependency needs (a high dependency unit).

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 male high dependency acute mental health ward.

The Dene has been inspected four times previously by CQC, in November 2012, April 2013, October 2013 and July 2015. Requirement notices were issued in the report from the July 2015 inspection and this report was sent to the provider at the same time as this report. We therefore did not test the service's compliance with these notices at this inspection.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a specialist advisor.

Why we carried out this inspection

We inspected this service to follow up information of concern that we had received in relation to the physical healthcare provided to patients. The inspection focused on the quality of physical health provided to patients in the hospital. This means that we have reported only under the domains within which physical health care is addressed.

How we carried out this inspection

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

During the inspection visit, the inspection team:

- visited all six 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 11 patients who were using the service;
- spoke with 10 staff;
- spoke with members of the hospital senior management team;
- attended and observed one hospital morning meeting;
- looked at nine care records of patients;

Summary of this inspection

- carried out a specific checks on the resuscitation equipment on all six wards;
- looked at a range of policies, procedures and other documents relating to the running of the service.
- reviewed staffing rotas and training;
- carried out a specific check on one ward's clinical room to see the arrangements for procurement of dressings.

What people who use the service say

Some patients told us that staff were kind. Patients told us that the wards were short staffed and this meant that leave and activities were often cancelled without notice. Two patients told us that staff did not always manage their physical health conditions properly.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Staff were not trained to manage and deliver many aspects of patients physical health needs.
- Patients were at risk of cross contamination from poor wound management.
- Staff did not escalate safeguarding concerns about their inability to meet peoples needs safely.
- Staff did not follow national guidance in relation to many aspects of patients physical health care.
- Patients were not provided with the prescribed dressing required for wound management.
- The provider failed to ensure that there was learning from their own investigations following a serious incident..
- There were high levels of agency staff employed who did not have the required training.
- Staff were identified to undertake roles when their training to do so had expired.

Are services effective?

- Staff did not always follow medicines management policies.
- Patient records were not always complete or accurate.
- Most staff had not received training in safeguarding children.

Detailed findings from this inspection

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.

On this inspection we did not assess the providers' compliance with the Mental Health Act.

Forensic inpatient/secure wards

Safe	
Effective	

Are forensic inpatient/secure wards safe?

Safe and clean environment

- All the wards in the hospital were single gender which meant that the provider complied with government guidance in respect of same sex accommodation. This reduced the risks that can be associated with mixed gender wards.
- All six wards were equipped with accessible resuscitation equipment. Each day staff checked that the equipment was in good working order. Emergency medication was all within date. Each ward kept records of this daily check. Staff on Amy Johnson ward had pre-signed the record for the following day. This put patients at risk of harm because it meant that the staff on duty the following day may consider the equipment had been checked when that was not the case.
- All the wards appeared clean and well organised. Furniture and equipment was appropriate for the needs of the patients. However, staff did not take proper steps to prevent cross infection. On the secure wards we saw two patients who had wounds with high levels of exudate (seepage) that were not being managed properly. The exudate soaked through patients clothing and unto flooring and furniture.
- The provider had guidance on cleaning blood or other body fluids to prevent cross contamination. Wards were also equipped with solutions to clean bodily spillages. However, despite visible marking from wound seepage on Michael Shepherd ward's floor, staff did not take any action to either renew the dressing, or clean the floor surface. This meant that other patients who had wounds were not protected from the risk of cross infection.
- Staff carried alarms to summon assistance and there was a hospital wide immediate response team that could attend and incident, if required. Patients' had access to nurse call systems that were fitted in their bedrooms and around the wards.

Safe staffing

- The provider has had challenges recruiting staff, particularly qualified nurses. At the time of our inspection 52% of qualified nursing posts were vacant. There was an 11% vacancy rate within the unqualified nursing.
- Some agency staff were described as "locum agency nurses". Locum agency staff were allocated to the wards with the aim of providing staff that were familiar to patients and ward routines. We were told that these workers were provided with the same training as the provider's permanent staff.
- The provider calculated that 49 qualified nursing shifts were required to cover all six wards on night duty over a period of one week. We saw that from 3 January 2016 to 10 January 2016 permanent nursing staff covered only six of these 49 night shifts. Leaving the remaining 43 qualified nurses shifts covered by agency or bank staff. On day duty for the same period the provider had calculated that a minimum of 72 qualified nursing shifts were needed to cover the wards. Between 3 January 2016 and 10 January 2016 35 of these 72 qualified nursing shifts were covered by agncy staff and 37 shifts were covered by permanent qualified staff.
- The service held no details on whether agency staff had training or expertise in managing chronic physical health conditions.
- Patients did not always get their leave or health appointments because of insufficient staff. One patient had their attendance at the Accident and Emergency unit postponed until additional staff were booked on night duty to escort them. A second patient had their planned dental appointment cancelled because there was insufficient staff on duty. On Amy Johnson ward we heard staff tell patients that they could not facilitate planned activities for that day as they were "very short of staff".

Assessing and managing risk to patients and staff

- We reviewed the pre-assessments of patients recently referred to the service, two of which the

multidisciplinary team decided to decline admitting the patients to the hospital. We saw that the multidisciplinary team decided to decline the admission because they judged they were unable to meet the two patients physical health needs.

- Risks to patient's health were identified either before or during the admission process. However, staff did not always put measures in place to manage and review these known risks. For example, one patient's record noted a "propensity to falling". The patient had previously sustained fractures from falling. Despite these known risks, staff had not undertaken a falls assessment nor made arrangements to reduce the risk of falls.
- For other patients, records showed risk of self-harming, but there were no care plans detailing the actions staff needed to take to reduce the risks of further injury.
- Staff were up to date with their safeguarding training. However the same level of training was provided for all grades of staff, even though they would have differing roles in respect of safeguarding patients and other vulnerable persons. The service made prompt referrals to the local authority safeguarding team, regarding most allegations of abuse or patient on patient assault. However, staff at all levels were not raising concerns when patients' needs were neglected.

Track record on safety

- The provider told us there had been 21 serious incident in the hospital in the previous 12 months. This included three unexpected deaths. However not all serious incidents were recorded and investigated in line with the providers reporting. During the inspection we found that a patient sustained a serious injury after an incident in the service. This was not recorded as a serious incident and there was no evidence of learning from the event. The absence of learning was reflected in the patient's care plan where there was no strategies recorded to reduce the risk of the event re-occuring.
- One patient who had a head injury caused by head banging events did not have assessment or early management as advised by the National Institute for Health and Care Excellence (NICE) Guidance: 'Head injury: assessment and early management'. Despite numerous instances of head banging, there was no care plan around how to manage this self-harm. Another patient had been the victim of an alleged patient on patient assault. A member of staff witnessed and recorded that whilst the victim was lying on the floor a second patient "kicked (them) very hard in the head". No emergency medical call was raised.
- Patients may or will be exposed to risk of harm and sepsis because their wounds were not being managed properly. For one patient there was no prescribed wound management plan in place.
- Staff were undertaking and recording Modified Early Warning Scores (MEWS). These were physiological checks such as temperature, pulse and blood pressure readings that indicate to staff if a patient's condition was deteriorating. During the inspection we saw that staff responded promptly when a patient suddenly became unwell. Staff closely monitored the patient's MEWS and maintained the patients safety whilst waiting for emergency services.

Reporting incidents and learning from when things go wrong

- Patients may or will be exposed to risk of harm because the provider was not monitoring and learning from incidents. Staff did not consistently report all notable incidents through the hospitals reporting system. This meant that the provider could not be assured that the information they had about incidents was accurate.
- There was limited learning from of serious events. In mid-November 2015 the provider reported on a preliminary review following a serious event. The review highlighted concerns about, staff ability to meet people's physical health needs particularly around management of patients wounds and the procurement of dressings and equipment to care for wounds adequately. Two months after the internal report we found inadequate wound care and management on three wards, prescribed dressings were not being procured properly, staff with responsibility for the monitoring wounds had not been provided with training in wound management. Staff were not responding appropriately to indications of wound infection. We escalated these issues to the hospital's senior management team who responded promptly to our concerns.
- We reviewed a week's record of hospital morning meetings where the provider had previously assured us

such matters were escalated and addressed. However concerns about patients' wound management, nor difficulty in procuring dressings, had not been escalated through to the senior management team in the hospital.

Are forensic inpatient/secure wards effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We checked records of 16 patients and found that 100% had a physical health assessment undertaken on admission and concerns about physical health issues were recorded. All planned admissions had an admission care plan and these addressed the further physical health investigations that staff needed to undertake within a timeframe.

Best practice in treatment and care

- Staff did not follow national guidance in the management and monitoring of patient's health problems. In the care records checked five patients were identified as having asthma. The British Thoracic Society have provided national guidance for supporting people with asthma. It stated that people with asthma should have personalised action plans that detail the early recognition of patient's asthmatic symptoms and the actions to be taken should there be deterioration in their breathing. None of the five patients had asthma care plans that detailed actions to take in the event of an episode.
- Risk management plans and care plans recorded that patients lung capacity should be monitored. However we checked on Michael Shepherd ward and staff were not aware of any equipment to monitor patients' lung capacity. Staff were unable to provide us with any records of peak flow readings for patients across all the wards.
- On Michael Shepherd and Amy Johnson wards we saw inadequate arrangements for the management of patient's wounds. One patient did not have the prescribed dressings in stock for an infected leg wound. The patient's care plan stated there was a graduated dressing frequency however we asked the two qualified permanent staff on the ward at what stage in the dressing program the wound was at. Neither staff were able to provide us with this information, nor could they direct us as to where we would find the information.
- Records for a second patient with a wound, showed that there was no care plan in place for the dressing and management of the wound. From the records we saw that on one occasion staff had declined to replace the patients wound dressing, despite their request. The patient was left with an open wound that seeped exudate through their clothing.
- On Wendy Orr a patient with a self-harm wound, had no care plan around the management of the wound. However records showed that staff on the ward were monitoring the wound and recording this on the patients daily records. Staff had also made arrangements for suture removal.
- Three patients were identified as at risk of deep venous thrombosis however National Institute for Health and Care Excellence (NICE) guidance: 'Edoxaban for treating and for preventing deep vein thrombosis and pulmonary embolism' advised that patients at risk or history of these events should be assessed regarding the probability of another event. However, the provider had not ensured such assessments were undertaken as no assessments had been completed.
- There was no nutritional screening to judge the patients' risk of malnutrition. A patient was identified as having an inadequate dietary intake. Their care plan stated that they were to have their weight recorded every two weeks and body mass index (BMI) recorded monthly. Staff were not following this plan, from the beginning of November 2015, the patient's weight had only been recorded on two occasions and there was no record of their BMI being monitored.
- Patients did not have equitable access to primary health care. This meant that they did not have access to health care professionals such as community nurses, continence advisors and tissue viability nurses. Patients did not have regular access to opticians. We saw a recent optician's appointment was arranged for a patient after their relative intervened. However this was cancelled due to low staffing levels.
- Patients were put at risk of harm of life threatening injuries because staff did not consistently respond

adequately to injuries or potential injuries. Patients who self-harmed by banging their head on a hard surfaces did not consistently receive proper medical attention. We reviewed four of patients' records and noted that service did not follow National Institute for Health and care Excellence (NICE) Guidance: 'Head injury: assessment and early management' for the assessment or early management of these patients following self-harm or assault events.

- Patients with diabetes were exposed to risk of harm caused by unstable blood sugar levels. Staff had failed to record a patient's blood sugar that had dropped during the night. A second patients' care plan noted that in the event their blood sugar rose above 20mmols they were to be administered insulin. We saw that on occasion this patients' blood sugar had reached 25mmols but staff had failed to follow the direction in the patients care plan.

Skilled staff to deliver care

- On the secure wards we saw incidents of patients sustaining self-harm injuries which resulted in wounds of varying degrees. However the provider had failed to provide training for staff on wound management. There was no registered general nurse to take a lead on patients' physical health care. The member of staff responsible for support staff with patients' physical health care was unqualified and not trained in the areas they had responsibility. Apart from venepuncture we saw that the provider had ensured the member of staff had been provided with appropriate training for their role.
- Most staff were up to date with life support training. However on one ward, two of the qualified nurses were not up to date with immediate life support training. On checking staff allocation records for January 2016, we saw that for two days one of these nurses had been the designated immediate life support responder for the hospital. This meant that in the event of a life threatening event the provider had allocated a nurse for whom their training to undertake the task had expired.
- Whilst there were future plans for the member of staff development the provider had not ensured they had the training, qualifications and or in wound and infection control management training on wound management, or many of the chronic health conditions experienced by patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Undertake a prioritised review of patients' physical health care needs. This should be undertaken by suitably qualified and skilled health care professionals, who have experience of meeting the physical health needs of the patient group.
- Ensure that the physical health care pathways care is in line with national guidelines for the management of physical health conditions experienced by patients.
- The provider must ensure ensure patients have equitable access to primary health care professionals.
- The provider must ensure sufficient and appropriately qualified staff to meet the physical health care needs of patients.
- The provider must ensure staff are appropriately trained in the safeguarding of adults and children.
- The provider must ensure there are appropriate systems in place for all staff to escalate and raise concerns about the care and treatment provided to patients.

This section is primarily information for the provider

Enforcement actions

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against the risks associated with inadequate physical heathcare and incompetent staff to deal with physical health issues. This is a breach of Regulation 12