Inadequate

Isle of Wight NHS Trust

Wards for older people with mental health problems

Quality Report

St. Mary's Hospital,
Parkhurst Rd,
Newport
PO30 5TG
Tel:01983 822099
Website:http://www.iow.nhs.uk/

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1FX8	Shackleton ward	R1FX8 Older people's mental health ward	PO30 5TG
R1F01	Afton ward	Older people's mental health ward	PO30 5TG

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

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

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

Summary of findings

Ratings

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

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

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

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

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

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

Summary of findings

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Overall summary

We rated the wards for older people with mental health problems as inadequate because:

- Following our inspection visit we issued a Section 31 notice of decision to urgently impose conditions on the registered provider as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so. The notice was in respect of the provider, the Isle of Wight NHS Trust, and covered failings identified at a number of the provider's core services. In respect of the provider's mental health inpatient services, including its wards for older people with mental health problems, the notice related primarily to the safety of the physical ward environments.
- We identified issues in relation to the safety of the environment at both wards. Although some of these issues had been identified by the trust's staff, they had not been effectively addressed and the provider did not have appropriate plans in place to address them at the time of inspection. We found significant concerns with Shackleton ward's seclusion room which, although required to meet strict legal requirements, was unfit for the purpose of seclusion. We also had serious concerns about further specific issues with the environments on each ward which impacted greatly on the dignity and privacy of patients. Neither of the wards visited was an appropriate environment for effectively promoting the recovery, comfort and dignity of patients. When we revisited the wards on 18 and 19 January 2017, we found the trust had taken steps to address the most immediate concerns with the environments on both wards to better ensure the safety, dignity and privacy of patients.
- We were not assured that shifts were covered by sufficient numbers of staff of the right grades and experience for the acuity of patients. An earlier safer staffing pledge had not been realised, which left both wards down on assessed nursing staff levels. About a third of the front line staff had not received or were out of date with essential training in physical intervention.
- We were concerned that potentially inconsistent and inaccurate recording and reporting of incidents meant that the provider could not be assured that incident data collected was accurate and reflected the actual number or detail of incidents, or the current risks within the service.
- Wards were not able to offer or provide a range of appropriate psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE). Afton ward had to take on increasing numbers mental health patients with organic conditions, largely due to the lack of specialist dementia places on Shackleton ward and in the island's residential and nursing homes. Staff on both Shackleton and Afton wards had not received training in caring for patients with dementia. Not all patient risk assessments had been regularly updated. Care plans were not holistic or sufficiently person centred or recovery orientated. Not all assessments were regularly reviewed. We saw insufficient evidence to demonstrate that patients were fully and effectively involved in their own care.
- There were significant problems related to the availability of specialised dementia places on the island. Although this was largely beyond the control of ward staff, it was impacting directly on the care they were able to provide. The seven beds on Shackleton were generally occupied by long-term patients. As a result of beds on Shackleton being continually occupied, people with dementia were being increasingly admitted on to Afton ward. This was causing difficulties with the patient mix, leading to unrest among patients.
- Staff had a sense of disconnect between themselves, the wider trust and the senior management team. They were unclear as to the trust's vision and values, and felt that mental health provision was not a priority for the trust. Morale had been badly affected because they felt little or no action had been taken by the trust in response to their concerns about issues such as staffing and the ward environments. Similarly, clinical staff felt there was insufficient understanding, at a senior trust management level, of mental health and the pressures the services were under.

However:

Summary of findings

- Staff undertook physical examinations on admission and we saw evidence of appropriate ongoing physical care. Junior medical staff were well supervised, and consultants were approachable and enjoyed teaching and supervising. Mandatory training and electronic learning included areas such as safeguarding, infection control, Mental Health Act and Health and Safety, with which the majority of staff were up to date. There was generally good access to support from other teams at the hospital, including support with palliative care for patients who were nearing end of life, input from tissue viability nurses for skin care and input from the speech and language team for patients who had specific eating or dietary needs.
- Staff on both wards visited were respectful and supportive to their patients, and responsive to their needs. The patients we spoke with all spoke positively of the care and support they received from ward staff, and said that their doctors were caring and listened to them. Despite limitations with the physical environments and other pressures such as staffing, staff tried hard to provide meaningful activities for their patients.
- Information in different formats was displayed in prominent positions and available to patients on the wards. Wards were able to cater for all specific diets and food requirements; including for those with specific cultural or religious needs and for people with medical dietary requirements.
- On a local level, staff and ward managers told us that their immediate managers supported them well. Staff told us their teams were cohesive, and colleagues were described as welcoming and supportive. Ward staff told us they felt comfortable raising their concerns or speaking up, without fear of recrimination or victimisation.
- When we revisited the wards on 18 and 19 January 2017 to follow up the S31 notice we had served on the trust, we found that appropriate steps had been taken to address the most urgent safety concerns with the environment and that plans were in place to carry out further necessary major improvement works.
- At the return visit, staff also spoke positively about how mental health now seemed a higher priority. Staff also told us that they felt more involved and included by the trust's managers, who they felt were listening to them and engaging openly with them in respect of improvements taking place.

Summary of findings

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

Are services safe?

Inadequate

We rated safe as inadequate because:

- We identified multiple issues related to the safety and fitness for purpose of the environments at both Shackleton and Afton wards. This included ligature points, poor lines of sight, and a poorly maintained outside space and insecure perimeter fence on Afton ward. We found significant concerns with Shackleton ward's seclusion room which, although required to meet strict legal requirements, we found was unfit for the purpose of seclusion. Although some of these risks had also been identified by the trust's staff, they had not been effectively addressed by the provider at the time of inspection. When we revisited the wards on 18 and 19 January 2017 to follow up the S31 notice, we found that appropriate steps had been taken to address the most urgent safety concerns with the environment and that plans were in place to carry out further necessary major improvement works.
- Despite having been assessed as necessary to meet the acuity of patients, the trust's own previous 'safer staffing' promise of additional staff for both wards had never been implemented.
- Not all patient risk assessments had been regularly updated. We also identified a problem with duplication of paper and electronic records, when risk assessments did not match up.
- Physical intervention training data provided by the trust for the two wards revealed that a third of the front line staff who were required to undergo mandatory training in physical interventions were not up to date with that training. This was potentially putting both staff and patients at risk, because physical restraint was used daily to support people. Incident data showed multiple incidents of aggression and violence involving patients with dementia on both wards.
- We identified a number of concerns in relation to the safe management of medicines.
- We were concerned that potentially inconsistent and inaccurate recording and reporting of incidents meant that the provider could not be assured that incident data collected was accurate and reflected the actual number or detail of incidents, or the current risks within the service. It also meant that potential trends or near misses might not be identified to learn from and prevent future incidents. The failings identified meant it would be very difficult for the inspectors, local commissioners and the provider itself to get a clear understanding and accurate assessment of the service's track record on safety.

Summary of findings

However:

- Staff on the two wards were up to date with mandatory safeguarding training. We were given examples of appropriate safeguarding alerts raised by ward staff in the last 12 months.
- We saw evidence of a small number of recent adverse events specific to this core service and steps taken by the provider to make improvements in safety following the events.
- When we revisited the wards on 18 and 19 January 2017, we found that the trust had decommissioned the room and seclusion was no longer being carried out on the ward.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Care plans were not holistic or sufficiently person centred or recovery orientated. Not all assessments were regularly reviewed. We identified a number of gaps and errors in the care records looked at on both wards.
- Care records consisted of a mix of electronic and paper documents. We were concerned that this caused scope for confusion and duplication and identified an example of how this also led potentially to unnecessary risk to patients.
- Wards were not able to offer or provide a range of appropriate psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE).
- There were pressures related to other reductions in services due to recruitment difficulties and funding cuts.
- We identified further gaps in respect of other key disciplines that would ordinarily be expected to provide input to older persons' inpatient mental health services. For example, there were no ward-based occupational therapists and no dedicated physiotherapy support for either ward.
- While medical staff had been well supervised, staff on Shackleton ward had only recently started to receive regular supervision. Further, staff development at ward level had been under increasing pressure.
- Afton ward had to take on increasing numbers of patients with organic mental health conditions, largely due to the lack of specialist dementia places on Shackleton ward and across the island. Information subsequently supplied by the trust confirmed that staff on both Shackleton and Afton wards had not received training in caring for patients with dementia.
- The trust had failed to meet its legal obligations under the Mental Capacity Act 2005. The recording of mental capacity was

poor and inconsistent from patient to patient. In some instances no supporting statement was found in ward round notes when people had been labelled as lacking mental capacity, or a statement said simply the patient had 'no capacity to make decisions'. Decisions to provide covert medication were not accompanied by appropriate mental capacity assessments and best interest decision making processes.

However:

- We saw evidence to confirm that physical examinations were undertaken on admission and targeted examinations and investigations followed when required, and saw evidence of appropriate ongoing physical care.
- Junior medical staff were well supervised and that consultants were approachable and enjoyed teaching and supervising. Consultants themselves had effective peer supervision and annual appraisals, and were also able to attend specialist courses. A weekly training programme was run for case discussions for medical staff and which provided further training opportunities for juniors.
- Ward staff told us they were able to access a variety of mandatory training and electronic learning. This included areas such as safeguarding, infection control, Mental Health Act and Health and Safety, with which the majority of staff were up to date.
- Clinical staff told us there was generally good access to support from other teams at the hospital. This included support with palliative care for patients who were nearing end of life, input from tissue viability nurses for skin care and input from the speech and language team for patients who had specific eating or dietary needs.

Are services caring?

Good

We rated caring as good because:

- We observed at both wards visited that staff were respectful and supportive to their patients, and responsive to their needs. The patients we spoke with all spoke positively of the care and support they received from ward staff, and said that their doctors were caring and listened to them.

However:

- We saw insufficient evidence to demonstrate that patients were fully and effectively involved in their own care.

Summary of findings

Are services responsive to people's needs?

Inadequate

We rated responsive as inadequate because:

- We found that neither of the wards visited was an appropriate environment for effectively promoting the recovery, comfort and dignity of patients.
- We identified serious concerns about the environments at both wards, with issues which impacted greatly on the dignity and privacy of both patient groups. On Shackleton ward, there were no curtains, blinds or other appropriate coverings on six of the seven patient bedrooms. This meant that patients in any of those rooms were potentially entirely visible to the general public in the busy public areas directly outside the ward. On Afton ward, we also identified problems with the environment that compromised patients' privacy, dignity and confidentiality.
- We found there were significant problems related to the availability of specialised dementia places in care or nursing homes on the island. Although this was largely beyond the control of ward staff, it was impacting directly on the care they were able to provide.
- The seven beds on Shackleton were generally occupied by long-term patients. As a result of beds on Shackleton being continually occupied, dementia patients were being increasingly admitted on to Afton ward. This was causing difficulties with the patient mix, leading to unrest among patients.

However:

- When we revisited the wards on 18 and 19 January 2017, we found the trust had taken steps to address the most immediate concerns with the environments on both wards to better ensure the dignity and privacy of patients. On Shackleton ward, blinds had been fitted to all bedroom windows. On Afton ward, curtains had been fitted to a seating area which allowed for greater privacy from the adjoining public car park if patients chose to close the curtains.
- Despite limitations with the physical environments and other pressures such as staffing, staff tried hard to provide meaningful activities for their patients.
- Hot and cold drinks were available to patients on both wards 24 hours a day
- Information leaflets were displayed in prominent positions on the wards. Staff were able to access information leaflets in different languages and formats if needed, and had access to a list of staff across the site who spoke different languages, which was a resource they could access to support communication with patients for whom english was not a first language. Wards

Summary of findings

were able to cater for all specific diets and food requirements; including for those with specific cultural or religious needs and for people with medical dietary requirements. Patients from Afton ward were able to visit regularly the hospital chapel, in support of their spiritual needs.

- When we revisited the wards on 18 and 19 January 2017, we were told by the trust's senior management team that plans were being progressed to redesign the service and relocate Shackleton ward to a location much better suited to meeting the needs of patients. Although no firm decision had been reached, we were assured that the decision would be made and communicated to staff, patients and other stakeholders by April 2017.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Staff had a sense of disconnect between themselves, the wider trust and the senior management team. Most of the staff we spoke with were unclear as to the trust's vision and values, and felt that mental health provision was not a priority for the trust.
- We identified multiple concerns about the safety and fitness for purpose of the environment at both Shackleton and Afton wards. The trust did not have the necessary systems and processes in place to identify effectively such concerns, or the plans to effectively address many of the risks and concerns we identified. Action the provider had planned to improve the environment on the wards was limited in scope, and did not include any of the essential improvements to the environment which we identified as being necessary during our inspection.
- Staff morale had been badly affected because little or no action had been taken by the trust in response to concerns they had raised about issues such as staffing and ward environments. Furthermore, they thought the situation was deteriorating and referred to feeling increasingly disempowered. Similarly, clinical staff felt there was insufficient understanding, at a senior trust management level, of mental health and the pressures the services were under.

However:

- The majority of staff across the two wards were up to date with their mandatory training.

Summary of findings

- Staff were able to submit items to the trust risk register, and staffing and ward furnishings were given as examples of entries made by staff. Ward managers told us they got quarterly reports key performance indicators such as incidents, use of restraint, falls, and pressure ulcers.
- At a local level, staff and ward managers felt their immediate managers supported them well. Staff told us their teams were cohesive, and colleagues were described as welcoming and supportive.
- Ward staff told us they felt comfortable raising their concerns or speaking up, without fear of recrimination or victimisation.
- When we revisited the wards on 18 and 19 January 2017 to follow up the S31 notice we had served on the trust, staff spoke positively about how mental health now seemed a higher priority. Staff also told us that they felt more involved and included by the trust's managers, whom they said were listening to and engaging openly with them in respect of improvements taking place.

Summary of findings

Information about the service

The wards for older people with mental health problems are part of Isle of Wight NHS Trust's services. They provide inpatient support to older people who have mental health needs. There are two wards specifically for older people with mental health needs; Shackleton and Afton wards, both based on the main St Mary's hospital site. Both wards admit male and female patients.

Shackleton is a seven bed ward ward for older adults with organic mental health conditions. Most of the patients have dementia and many also have challenging behaviour. The majority of patients are detained under the mental health act, but one patient was under the deprivation of liberty safeguards at the time of our inspection.

Afton is a 12 bed ward primarily for patients with functional mental health conditions. Some of the patients are under voluntary admission and others detained under the MHA. The ward also has a number of patients with a primary diagnosis of organic mental disorder who cannot be admitted to Shackleton ward due to lack of beds.

Our inspection team

The inspection was led by Joyce Frederick, head of hospital inspections.

The team that inspected this core service comprised an inspector team leader, inspection manager, psychiatrist and a mental health act reviewer.

Why we carried out this inspection

We inspected this core service as part to a short notice inspection to follow up on some areas that we had previously identified as requiring improvement or were we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously.

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, we reviewed information that we held about wards for older people with mental health problems and requested information from the trust.

During the inspection visit, the inspection team:

- Visited two of the inpatient mental health services for older people, based at the main St Mary's hospital site
- Looked at the quality of the environment at each location
- Spoke with five patients
- Spoke with the managers for each of the teams
- Spoke with nine other staff members made up of consultant psychiatrists, doctors, team leaders, mental health nurses and nursing assistants
- Looked at care records of nine patients
- Looked at medication records for nine patients at the two wards visited
- Looked at a range of policies, procedures and other documents relating to the running of the services

Summary of findings

- Carried out a Mental Health Act review at Shackleton ward
- Gathered six feedback forms from patients who used the service.

In addition, we subsequently carried out a focused inspection visit to both wards on 18 and 19 January 2017.

The aim of this return visit was to seek assurance that the urgent risks found during the initial inspection visit in November 2016, that had led to CQC taking enforcement action through a S31 notice, were being addressed.

What people who use the provider's services say

Patients told us that staff were caring and that their doctors listened to them. They felt the wards were clean and there was an excellent laundry service. They liked that they had access to drinks whenever they wanted them. Although people felt staff did the best they could to provide them with activities, they told us they wanted more activities to do. We also gathered six feedback forms from patients who used the service, which were all positive about the ward staff and the care they gave.

Areas for improvement

Action the provider MUST take to improve

- The provider must assess and address in full the risks associated with the physical ward environments. Until the necessary changes are made to make the environments as safe as possible, appropriate measures must be implemented to mitigate effectively the risks to people using the service.
- The provider must ensure its seclusion facilities comply with legislation and recognised national guidelines.
- The provider must ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff are deployed to meet patients' care and treatment needs.
- The provider must take steps to ensure that all patients' risk assessments are updated, accurately reflect the specific risks and contain the necessary steps to mitigate the risks.
- The provider must ensure that all front line staff receive appropriate physical intervention training to be able to safely manage aggressive or agitated patients.
- The provider must ensure it has appropriate systems and processes in place for the safe management of medicines.
- The provider must take appropriate steps to demonstrate that care and treatment are provided with the consent of each patient or other relevant person, and be able to demonstrate that they act in accordance with the Mental Capacity Act 2005 (MCA) in all instances where a patient lacks mental capacity to make specific decisions and to consent to their care and treatment.
- The provider must review the provision of psychological therapies and psychosocial interventions to ensure it meets people's treatment needs.
- The provider must take steps to ensure and demonstrate that the care and treatment of patients is appropriate, meets their needs and reflects their preferences.
- The provider must ensure that patients are treated with dignity and respect and that their privacy is upheld at all times.
- The provider must ensure they have appropriate systems in place for the safe and effective governance of its services.

Action the provider SHOULD take to improve

- The provider should make every effort to recruit nursing staff to identified vacancies in order to address issues in relation to the lack of qualified permanent staff.
- The provider should ensure all front line staff have updated Mental Capacity Act training in order to help ensure teams work in line with statutory requirements at all times.

Summary of findings

- The provider should increase its focus, through effective and holistic care planning and joined up MDT working, on patients' recovery and rehabilitation.
- The provider should involve ward staff fully in any future redesign and refurbishment of the ward environments.

Isle of Wight NHS Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Shackleton ward	R1FX8
Afton ward	R1F01

Mental Health Act responsibilities

We reviewed adherence to the MHA during our inspection and found the following:

- Training figures supplied by the trust showed that 90% of eligible staff across the two wards were up to date with the trust's mandatory MHA training.
- A separate Mental Health Act review of Shackleton ward was carried out by a specialist Mental Health Act Reviewer (MHAR) during this inspection visit. The findings from that visit are covered in detail in the separate MHAR report for that review. However, the key concerns raised through the MHAR's review were in line with the findings of the inspection team and are summarised below.
- The ward physical environment did not afford patients sufficient privacy and dignity. We were also concerned that gender segregation requirements had not been adhered to.
- In relation to the use of the seclusion room on Shackleton ward, staff 's understanding and the documentation and policy to control its use which we were shown did not assure us that there was an awareness or proper understanding of Chapter 26 of the Mental Health Act code of practice. We also did not see evidence of a 'reducing restrictive interventions' programme on this ward.
- There was an independent Mental Health Act advocate (IMHA) allocated to the ward. However, we did not see documentary evidence of referrals to the IMHA and we were told that IMHA input was by referral rather than routine. One patient had no nearest relative, but we found no evidence of an IMHA referral for them as should have been the case.

Detailed findings

- The provider has been required to submit an action statement in response to the MHAR report, which will detail precisely the steps they will take to ensure the issue raised are addressed in order to meet the requirements of the legislation.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed the records of two patients on Shackleton ward who were receiving covert medication. Both patients had received visits from a Second Opinion Appointed Doctor, confirming their lack of mental capacity to consent to medication. However, no subsequent best interest meetings had been held with the patients' appropriate family members, advocates and health professional such as pharmacy to ensure the patients' best interests were being met.
- We reviewed care records for four patients on Shackleton ward and checked for assessments of mental capacity. The recording of mental capacity was poor and inconstant from patient to patient. We observed the recording of mental capacity in ward round notes was ad hoc. In some instances no supporting statement was found in ward round notes when people had been labelled as lacking mental capacity, or a statement said simply the patient had 'no capacity to make decisions.' We found decisions recorded by medical staff in ward round notes to provide covert medication, but these were not accompanied by appropriate mental capacity assessments and best interest decision making processes.
- Several different styles of mental capacity assessments were seen in care records. None of the assessments provided rationale for the actual judgement as to the patient's mental capacity and none were decision specific. We found assessments which had been crossed out and over written with the phrase, 'Patient on Section 2 of Mental Health Act'. The detention of a patient under the Mental Health Act does not supersede the need to assume mental capacity for all decisions.
- We identified a difference of clinical opinion as to a patient's mental capacity to consent to treatment and medication in their care records. This was raised with the ward manager on Shackleton ward at the time of our visit.
- Staff told us that they had not received MCA training in some time. Mandatory training records provided by the trust for Afton and Shackleton ward revealed that only one member of staff had completed the E-Learning training module which covered the MCA. The ward manager confirmed our findings, and stated that they had identified and acknowledged, internally within the ward's staff team that they were failing to meet the requirements of the Act.

Inadequate

Are services safe?

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

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

Our findings

Safe and clean ward environment

- We identified a number of serious concerns in relation to patient safety at a number of the provider's mental health core services, including the older persons inpatient mental health services. In relation to the two older persons mental health wards, our concerns were specifically connected to the safety of the physical environments. We subsequently issued a section 31 notice of decision to urgently impose conditions on the trust, as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so. Details relating specifically to older persons inpatient mental health services can be found at the end of this report.
- We identified multiple issues related to the safety and fitness for purpose of the environments at both Shackleton and Afton wards. Many of the issues we identified were known to ward staff, but it had been beyond the scope of their powers and influence to effect the changes and improvements they had wanted made.
- On Shackleton ward we identified a number of concerns with the environment. Due to the design of the ward, there were blind spots which could only be effectively covered by staff standing out on the ward to observe patients at all times. Communal rooms and patient bedrooms allowed unsupervised patients access to fixtures and fittings that could be used as ligature points. For example, window catches on all bedroom windows and bathroom fittings. A ligature point is an environmental feature or structure that is load bearing and can be used to secure a cord, sheet or other tether that can then be used as a means of hanging. Although they are potentially of a greater risk to patients on a functional mental health ward, and the risk has to be balanced against the need to meet the mobility needs of elderly and infirm patients through adaptions and aids, there were a number of significant and unnecessary ligature points which had not been removed or effectively mitigated.
- We identified issues with the maintenance and upkeep of the ward. An electric socket was badly damaged and had exposed live cables. This presented an immediate risk to patients and staff, so we raised it with senior staff at the time and requested it be repaired as a matter of priority. In a communal bathroom, the decoration was poor where fittings had been removed and not repaired. The window catches were broken on one bedroom and particularly dangerous. We were told they had been broken for over a week but had not been repaired. Again, we raised this with senior managers at the time of the inspection. We subsequently found that a number of other bedroom window catches had been broken and repaired on numerous occasions. Although all ward areas were visibly clean, the decoration was poor in parts, drab and in need of updating. Furniture was generally in good condition, but was taken from different services and of a variety of different styles, none of which were particularly well suited to meeting needs of the patient group.
- We were concerned about an interconnecting or 'Jack and Jill' bathroom between two of the seven bedrooms. This was a shared bathroom, with access doors from the two bedrooms either side. It presented a number of risks to patients' personal safety. For example, there had been an incident where a patient had managed to get through the bathroom into the bedroom of the patient in the adjoining room. It also presented infection control risks, as was potentially the case during the inspection, when both patients were nursed in isolation due to possible infection. It also created the risk that patients could get either locked in the bathroom or locked out of the bathroom due to a faulty and temperamental locking mechanism. We discussed this with the ward manager at the time of inspection, and it was clear from the steps they had taken that they had done the best they could to manage – with understandably limited success - the risks associated with a bathroom that was inherently unsafe and not fit for purpose for the patients using it. When we revisited the wards on 18 and 19 January 2017 we found that the bathroom had been locked off and was no longer in use, which removed the immediate safety risks concerning its use.
- There was a female lounge available, but it was not appropriate to the patient group. It was unwelcoming, was not dementia-friendly, and it contained a mixed selection of potentially dangerous chairs including ones

with hard wooden arms on which patients might hurt themselves if they fell. There were no curtains or window coverings. Staff told us that due to its limitations the room was rarely used by patients.

- In addition, we identified a number of other issues that indicated the safety and needs of patients had not been prioritised in the ward's design and use. Electrical boxes were kept behind openable panels in bedrooms. These were accessible to mobile patients and presented a possible risk of electrocution. Conversely, the nurse call system was not accessible to patients in a number of bedrooms. We were concerned about moveable, heavy furniture in bedrooms, as this presented a risk of falling on to patients, in particular one person who we saw liked to move furniture and did so much of the time we were on the ward. Moveable bedside cabinets had recently been removed from bedrooms, following an incident where a patient had sustained a serious injury after a fall when they had tried to steady themselves on a cabinet and it had rolled away from them. In one bedroom we found a sponge ball had been taped over a sizeable spike on the patient's bed head. This did not provide any real protection and presented a clear risk to the patient, who would sustain a serious injury if they fell against it. We raised this with senior staff at the time of inspection, who then ensured that the bed was replaced during our visit. When we revisited the wards on 18 and 19 January 2017 we found that appropriate steps had been taken to address most of the urgent safety concerns with the environment. For example, wardrobes had been fixed to walls so no longer presented a risk of falling on patients. However, we were concerned to find that electrical boxes behind panels in bedrooms were still accessible. In one bedroom, we found the panel was easy to open and contained a live call bell and cable inside it. Staff gave us assurance that the estates team would be notified immediatey and all such panels made secure, so as to prevent patients accessing them.
- Staff told us the ward's environment was the most negative part of the service, and that that it made it extremely difficult for them to safely manage and meet the needs of the patient group. They had raised their concerns about the environment on Shackleton wards for several years, before and then since the older persons organic mental health service had moved on to the ward. When we revisited the wards on 18 and 19 January 2017, staff spoke positively about how they felt senior managers were now listening to them and engaging openly with them in respect of changes and improvements taking place.
- We identified similar concerns with the safety of the environment on Afton ward, which is a 12 bedded ward for functional patients. Some of the patients were detained and several had a diagnosis of severe depression and had been judged to be suicidal on their admission to the ward. Despite the increased risk of self-harm in this patient group, we identified there were multiple ligature risks throughout. The provider had taken some steps to remove ligature points, including installing new ligature-proof windows. However, patients were able to have unsupervised access to many of the identified remaining ligature points. These included fixed and weight-bearing clothes rails, bathroom fittings in connecting 'swing' bathrooms, exposed pipework and cabling. When we revisited the wards on 18 and 19 January 2017, we found that steps had been taken to remove or mitigate some of the more obvious ligature risks. Clothes rails and wardrobe doors had been removed, exposed pipework and cabling had been boxed in.
- The communal bathroom had a deep sided assisted bath, with standard fittings and a hoist over. Patients were able to use the bathroom unsupervised, which meant they were potentially at increased risk from both drowning and from potential ligature points. We also identified a significant issue with the interconnecting 'Jack and Jill' bathrooms which were in use for all bedrooms. Similar to the situation at Shackleton, these shared and interconnecting bathrooms presented risks to patients' personal safety, infection control risks, and the potential for patients from bedrooms either side to get locked in the bathroom or locked out of the bathroom due to faulty and temperamental locking mechanisms (staff had blue-tacked coins to the walls outside of the bathrooms on Afton ward, to use to open them from the outside in the event of the locks not working from the inside, which demonstrated clearly that the locking system was faulty). We were told that bed pressures had resulted in males and females having to share the interconnecting bathrooms, which went against the Mental Health Act Code of Practice guidance regarding same sex accommodation. When we revisited the wards on 18 and 19 January 2017 we found that the

bathrooms were locked off when not in use. Staff told us that patients of opposite sex were now also not put in adjoining bedrooms and so no longer shared bathrooms. We also discussed planned works, which included major upgrades to all of the bathrooms on the ward to ensure they had minimal ligature risks but also met the mobility and assistance needs of patients, with senior trust representatives.

- The outside garden space was unsafe and unfit for purpose. Overall, the garden was poorly maintained. Steps were broken, collapsing and very slippery. Paths were uneven and broken, and it was landscaped into different tiers, which presented fall and trip hazards. Incident figures supplied to us by the trust showed there had been at least three separate patient falls in the garden in the previous 12 months and two of those were related to the garden's layout. The perimeter fence was unsecured as the gate latch was broken and the gate unlocked, so the general public were able to walk freely into the garden and patients, including those who were detained, were potentially able to walk out of the garden. Incident data recorded that a patient had attempted to abscond from the garden earlier in the year. There were multiple ligature risks, including down pipes for drainpipes and a long length of garden hose. There were additional climbing and absconding risks, including a low level fence next to a higher fence and garden furniture which was easily moveable, which allowed for easy climbing. It was confirmed by staff that there had been incidents of patients from the neighbouring acute ward climbing over and into the Afton ward garden. When we revisited the wards on 18 and 19 January 2017 we found that the garden had been locked off and patients were only able to access it under strict supervision. The steps and broken paths had also been cordoned off. We were given assurance that the outside space was to be redeveloped and redesigned so as to better meet the needs of patients, but plans for this had not been finalised at the time of our return visit.

- Although the ward was visibly clean throughout, it had not been properly maintained. In addition to the poor state of the garden, we saw there were large cracks in the ceilings in the main lounge area. Staff told us that when it rained heavily, then water leaked in through the skylights in this area.

- Ward staff told us that there were plans for major works to be carried out at the ward, which would address some of the more significant areas of concern. For example, all bathrooms were to be refitted in order to make them more ligature safe. Similarly, there were plans for modifications to the nurses' station and for redecoration throughout. However, staff told us that it was difficult and lengthy process to get any changes or improvements made to the environment. They referred to a six month process for any works costing more than a couple of hundred pounds. We were told that the broken garden gate had been raised several months earlier internally by staff as an issue which needed to be addressed, but this had still not been made secure at the time of our visit. When we revisited the ward on 18 and 19 January 2017 we found that the garden gate had been made secure. Staff also told us on the return visit that the process of getting jobs carried out had improved and it was now quicker and easier to get maintenance carried out.

- We subsequently requested formal plans from the trust of all major works to be carried out on Shackleton and Afton wards. We also requested environmental risk assessments, including for ligature risks, for the past three years for both wards. The trust sent us a large number of documents in response to our request, but none of the assessments covered or identified most of the issues we had found with the environments on the two wards. Furthermore, the plan of works they sent though to us was a business case for general refurbishment of the Sevenacres site, which incorporated only Afton ward and not Shackleton ward. The business case, dated and signed off December 2016, was for cosmetic tidying and redecorating of the Sevenacres site, including replacement of all furniture. The proposed plan of works addressed none of the significant risks presented by the environment, including the multiple ligature risks, nor did it cover the outside space at Afton ward. Furthermore, the trust sent us a large number of individual documents in response to our request for their environmental risk assessments. None of the documents identified or contained reference to the physical risks we identified with the environment on the wards at our inspection visit. The trust did send us through recent ligature assessments for the wards, dated for review December 2016, which

Inadequate

Are services safe?

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

identified and classed as 'to be urgently addressed' a number of the ligature points we had found. However, these assessments contained no action plan or scheduled dates for the removal of the risks.

- Following our S31 notice, the trust took appropriate steps within the stipulated timescale to begin to address these issues. For example, comprehensive ligature assessments were carried out at the two wards and detailed action plans drawn up for the removal and mitigation of many of the different risks identified.

Safe staffing

- Afton ward was operating at establishment level, with no vacancies at the time of our visit. This generally consisted of two nurses and two healthcare assistants (HCA) during the day, and one nurse and two HCAs during the night. It was recorded in minutes to the ward's staff team meeting from September 2016 that they were a nurse down at night, and that national guidance was that there should be a minimum of two nurses if there are more than eight patients. Staff told us that due to their acuity and the increasing numbers of patients with organic mental health conditions who could not be admitted to a more appropriate bed on Shackleton ward, this staffing level was insufficient to meeting all the needs of patients on the ward. The ward manager assured us they were able to get bank staff in, and that those staff knew the ward and the patients. However, a previous 'safer staffing' initiative promise of an additional nurse on early and night shifts had never been implemented. The impact on the ward was that staff were running at their limit, and there was no scope to provide support if there were incidents on other wards. Also, as there was only one nurse working on night shifts, they had to get the assistance of a nurse from another ward if they needed to administer any controlled drugs.

- Shackleton ward had a number of staff vacancies, including for two band 2 HCAs and three band 5 nurses, which meant they were running at almost 20% staff vacancy rate. They also had a member of staff on long term sick and an increased number of patients who required one to one staff support. This was putting considerable pressure on the existing staff team. In incident data supplied to us by the trust, there had been eight separate incidents logged in the previous 12 month period which staff had classed as staffing issues. The ward had no dedicated occupational therapist or physiotherapy support; and this, along with the staffing pressures, meant that the ward was functioning as a long stay high dependency unit, rather than a dementia assessment ward. They had gained agreement from the trust's senior managers to bring in two agency nurses for a period of three months to provide some essential cover. However, as at Afton ward the previous safer staffing increase had not happened. We subsequently requested the previous safer staffing initiative projection for the two wards. The trust did not supply us with the information requested.

Assessing and managing risk to patients and staff

- We looked at care records for nine patients, and saw that risk assessments had been carried out for each of them. However, not all risk assessments had been regularly updated. We also identified a problem with duplication of paper and electronic records, when the risk assessments did not match up. This was confusing, and had led to omissions. For example, a patient on Afton ward had made two suicide attempts, but there was a discrepancy between the electronic and paper risk assessment records as to whether they were still at risk of suicide. Another patient had two different versions of a risk assessment active, but the assessments did not reflect the individual's risks. We also found examples of known patient risks not being documented in risk assessments.

- There were 21 incident recorded of restraints across the wards in the six month period between 1 April and 30 September 2016. According to staff, and corroborated by data supplied by the trust, face down restraint was never used and rapid tranquilisation only rarely used. However, incident data showed multiple incidents of aggression and violence involving patients with dementia on both wards. Physical Intervention training data provided by the trust for the two wards revealed that only 28 out of 43 members of staff who were required to undergo mandatory physical intervention training were up to date with that training. Staff on both wards raised their concern that new staff on the wards had not received appropriate physical intervention training, and that many existing staff were out of date

with their training. They told us they felt this was potentially putting both staff and patients at risk, as physical restraint was used daily to support people with essential personal care for example.

- We had significant concern about Shackleton ward's seclusion room. Staff spoken with confirmed this had been and was used for the seclusion of patients. Accordingly, the room was required to meet strict legal requirements but we found it was unfit for the purpose of seclusion. It did not allow for clear observation of patients in seclusion at all times, the furnishings were unsuitable, there was no system for two-way communication, there was no ventilation as the windows were fixed shut so unable to be opened, there were no toilet or washing facilities and no clock. There were obvious ligature points, including the mirror installed to allow for observations of patients in seclusion. There were also no coverings on the windows, so anyone in seclusion was potentially entirely visible to the general public outside the ward in addition to anybody visiting the ward. When we revisited the ward on 18 and 19 January 2017, we found that the trust had decommissioned the room and seclusion was no longer being carried out on the ward.
- Almost all of the staff on the two wards were up to date with mandatory safeguarding training. Staff told us they felt that there was an effective safeguarding system in operation at the trust, and that senior colleagues would respond appropriately if safeguarding concerns were raised. We were given examples of appropriate safeguarding alerts raised by ward staff in the last 12 months.
- We identified a number of concerns in relation to the safe management of medicines. On Shackleton ward, we found controlled drugs were being stored in a locked but unfixed tin box within the drug cupboard. This was not in-line with national guidance related to the necessarily strict management of controlled drugs. Staff told us that prior to that week the controlled drugs had been kept in an open basket in the drug cupboard, which could have led to an even greater risk of their being misused. We checked current medication records, but were unable to find evidence of best interests meetings taking place for those patients who received their medication covertly. We found no evidence that pharmacists had advised about what foodstuff staff should dissolve or crush covert medication into, and saw no record to demonstrate the appropriate involvement of nearest relatives or independent mental health advocates.

Track record on safety

- We saw evidence of a small number of recent adverse events specific to this core service and steps taken by the provider to make improvements in safety following the events. These improvements had included staff retraining, increased staff observation of particularly vulnerable patients and changes to furniture in bedrooms.

Reporting incidents and learning from when things go wrong

- Following discussions with ward staff, we were concerned that potentially not all incidents which should have been recorded and reported had been. Two members of staff told us they did not report all incidents of violence and aggression by dementia patients, as it was a part of the patient's condition and too time consuming. Three member of staff stated they 'bunch' reported incidents. They described 'bunched' reporting as collating all the separate incidents of violent or aggressive behaviour across a shift for a patient and then recording and reporting them as a single incident. We found no 'bunched' incidents were recorded on the spreadsheet breakdown of incidents across the two wards which the trust sent to us following our visit so were unable to verify staff's claims or to assess the extent of this practice. Recording incidents in this way affects the accuracy of actual numbers of incidents collected and recorded, and potentially shows considerably fewer incidents than actually occur within a service. It also reduces the provider's ability to carry out essential oversight of trends. Staff told us that there were daily incident of violence involving dementia patients, yet Afton ward had only reported 31 separate incidents of violence, aggression or verbal abuse over a 12 month period. This suggested that staff were considerably under-reporting incidents. It also meant that potential trends or near misses might not be identified to learn from and prevent future incidents. The failings identified meant it would be very difficult for the inspectors, local commissioners and the provider itself to get a clear understanding and accurate assessment of the service's track record on safety.

Inadequate

Are services safe?

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- Staff told us they received individual feedback regarding reported incidents. We found one entry of learning from incidents in seven sets of team meeting minutes provided for the wards. The ward managers acknowledged that reporting and learning from incidents were not as good as they could be. They told us they were working on improvements in this area, with more reflective practice and better debriefing. They were also encouraging staff to record all incidents.

Are services effective?

Inadequate

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

Our findings

Assessment of needs and planning of care

- We reviewed the care records for five patients on Afton ward and four patients on Shackleton ward. We saw evidence to confirm that physical examinations were undertaken on admission and targeted examinations and investigations followed when required, and saw evidence of appropriate ongoing physical care. However, the care plans seen were not holistic or sufficiently person centred or recovery orientated. For example, on Afton ward a variety of care plans were made up from pre-written text. The back of the plans allowed for free text to be added; however, these were not regularly updated and in some case did not reflect the patients' clinical presentation as described by staff.
- In four of the records reviewed on Shackleton ward, we saw evidence of completed falls assessments, MUST nutrition assessments, MEWS early warning assessments to aid recognition of deteriorating patients, Waterlow skin assessments and bed rail assessments being carried out. However, not all assessments were regularly reviewed. For example, two patients' risk booklets had not been reviewed since September 2016 (trust policy was to review them weekly). In one of these examples, on two consecutive weeks the ward round notes requested a review of the patient's MEWS scores, but this had not been carried out. On Afton ward, the ward manager told us they checked and audited a selection of four patients' records monthly. All gaps or errors would then be followed up with the primary nurse with responsible for the care plan concerned. We identified a number of gaps and errors in the care records looked at on Afton ward, but there were fewer than those in the care records for patients on Shackleton ward. According to the minutes to the ward team meeting in August 2016, this was also the finding from an internal audit of Shackleton's care plans, which had highlighted overall compliance with the provider's identified care plan standards of 61%, which was the lowest of all the trust's mental health in-patient services.
- Care records consisted of a mix of electronic and paper documents. We were concerned that this caused scope for confusion and duplication, a point of concern which was also raised with us by staff on both wards. Paper records on Shackleton were spread over several folders, and we found the folders difficult to navigate. The care folders on Afton were also disorganised and difficult to navigate. This had the potential to cause confusion, especially for new staff or agency staff who were unfamiliar with the patients or the wards' systems. We identified an example of how this also led potentially to unnecessary risk to patients. A patient had a written care plan for swallowing difficulties, but this was not assimilated into the patient's electronic care plan. We observed a member of staff mashing up cake in ice cream for the patient, when the individual should only have had extremely smooth puree because of a risk of aspiration. We raised this specific concern with the appropriate member of staff at the time of the inspection, and they assured us they would take immediate steps to ensure staff followed the patient's most up-to-date care plan for swallowing in future.

Best practice in treatment and care

- Treatment plans viewed showed that staff followed some of the key National Institute for Health and Care Excellence (NICE) guidelines regarding medication. For example, we saw evidence of appropriate reductions of anti-psychotic medication.
- However, the wards were not able to offer or provide a range of appropriate psychological therapies as recommended by NICE. All of the medical staff interviewed, including a senior clinical lead expressed their regret that psychological therapies were not available to inpatients and there was very limited access for community older adult patients. This is in breach of NICE guidance for depression (Clinical guideline [CG90]), dementia [CG42] and schizophrenia (CG178). For example, cognitive behavioural therapy (CBT) – potentially essential treatment for some patients' conditions -was not available on the wards. A retired psychologist had previously provided a formulation session for the ward, which had been valued and extremely helpful, but their post was currently vacant.

Skilled staff to deliver care

- Staff also raised with us that there were issues and pressures related to other reductions in services due to recruitment difficulties. At the time of our inspection, the two older adult wards were being covered by a GP trainee and second foundation year junior doctor (F2), as there were difficulties in filling vacancies for core trainees in psychiatry. The consultants interviewed

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stated that there were some advantages in the routine work being reviewed by doctors who are up to date with physical health care, but that this required more consultant support for the mental heath aspects of assessment and treatment. The F2 doctor was covering nights at the time of our inspection so was not available to the wards during the day. Although consultants had an on-call rota and out of hours and night time medical cover were available, there was increased responsibility and pressure placed on junior doctors. We were told that there used to be a nurse assessor available to take calls from the community all day and seven days a week, but two months earlier this post had been cut. In theory, calls from the community should go to the crisis team for a response but they were instead being picked up at night by staff on another of the inpatient wards. Clinicians told us the loss of the nurse assessor post had a significant impact. Junior doctors covered all problems on site, but those doctors were often not core trainees in psychiatry, so had to to contact the on call consultants about community queries. There were vacancies covered by locums for consultant psychiatrists for adults of working age, but the consultants in older adult psychiatry were fully established and their input was much appreciated.

- We identified further gaps in respect of other key disciplines that would ordinarily be expected to provide input to older persons inpatient mental health services. For example, there were no ward-based occupational therapists. There was an activity coordinator on Afton, but they were part time and off sick at the time of our inspection. There was no activity co-ordinator on Shackleton ward, only what was described as a 'therapeutic middle', who was simply an extra pair of hands and not a dedicated specialist resource. There was no dedicated physiotherapy support for either ward. Pharmacist and social workers did attend ward rounds. Care coordinators from the generic team or home treatment team would also attend, if allocated, but there was no community mental health team specifically for older adults.
- We found that junior medical staff were well supervised and that consultants were approachable and enjoyed teaching and supervising. Consultants themselves had effective peer supervision and annual appraisals, and were also able to attend specialist courses. A weekly training programme was run for case discussions for medical staff and which provided further training opportunities for juniors. A GP trainee told us they attended monthly regional training. While medical staff had been well supervised, staff on Shackleton ward had only recently started regular supervision. We were told this was due to staffing pressures, which resulted in ward staff feeling they did not have time for supervision. We were told that staff development at ward level had been under increasing pressure, and that secondments for health care assistants (HCAs) to do their nurse training had become very difficult to arrange; but that a bid had recently been submitted to the trust board requesting for agreement to allow five HCAs from mental health inpatients services to complete the four year open university course to train as nurses.
- Ward staff told us they were able to access a variety of mandatory training and electronic learning. The ward managers were able to demonstrate the trust's electronic training record, which was very visual and made it easy for them to see exactly what training their staff had received, and what training staff were due or overdue. Figures supplied by the trust showed that the staff teams for the two wards had, at 92%, the highest overall compliance with their mandatory training. This included areas such as safeguarding, infection control, Mental Health Act and Health and Safety, with which the majority of staff were up to date. As discussed above and highlighted by staff, the only areas of mandatory training which were anomalous and of significant concern were people handling (65%) and physical intervention (67%).
- Afton ward was having to admit an increasing number of patients with organic mental health problems, largely due to the lack of specialist dementia places on Shackleton ward and across the island's care and nursing homes. Several different members of staff on Afton ward told us they did not receive training specific to meeting the care needs of dementia patients. We subsequently requested information from the trust about specialist training for staff, and the information supplied confirmed that staff on both Shackleton and Afton wards had not received training in caring for patients with dementia.

Multi-disciplinary and inter-agency team work

- Clinical staff told us there was generally good access to support from other teams at the hospital. This included support with palliative care for patients who were

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nearing end of life, input from tissue viability nurses for skin care and input from the speech and language team for patients who had specific eating or dietary needs. Ward staff also confirmed they had strong working relationships with hospital dieticians and speech and language services. We saw that multi disciplinary team (MDT) meetings took place three times a week on each ward, where professionals from different clinical disciplines met to discuss the treatment of individual patients. Decisions taken at the MDT meetings were then appropriately recorded on the trust's electronic records system.

Adherence to the MHA and the MHA Code of Practice

- Training figures supplied by the trust showed that 90% of eligible staff across the two wards were up to date with the trust's mandatory MHA training.
- A separate Mental Health Act review of Shackleton ward was carried out by a specialist mental health act reviewer (MHAR) during this inspection visit. The findings from that visit are covered in detail in the separate MHAR report for that review. However, the key concerns raised through the MHAR's review were in line with the findings of the inspection team and are summarised below.
- The ward physical environment did not afford patients sufficient privacy and dignity. We were also concerned that gender segregation requirements had not been adhered to.
- In relation to the use of the segregation room on Shackleton ward, staff 's understanding and the documentation and policy to control its use which we were shown did not assure us that there was an awareness or proper understanding of Chapter 26 of the Mental Health Act code of practice. We also did not see evidence of a 'reducing restrictive interventions' programme on this ward.
- There was an independent mental health act advocate (IMHA) allocated to the ward. However, we did not see documentary evidence of referrals to the IMHA and we were told that IMHA input was by referral rather than routine. One patient had no nearest relative, but we found no evidence of an IMHA referral for them as should have been the case.
- The provider has been required to submit an action statement in response to the MHAR report, which will detail precisely the steps they will take to ensure the issue raised are addressed in order to meet the requirements of the legislation.

Good practice in applying the MCA

- We reviewed the records of two patients on Shackleton ward who were receiving covert medication. Both patients had received visits from a Second Opinion Doctor (SOAD), confirming their lack of mental capacity to consent to medication. However, no subsequent best interest meetings had been held with the patient's appropriate family members, advocates and health professional such as pharmacy to ensure the patient's best interest were being met.
- We reviewed care records for four patients on Shackleton ward and checked for assessments of mental capacity. The recording of mental capacity was poor and inconstant from patient to patient. We observed the recording of mental capacity in ward round notes was ad hoc. In some instances no supporting statement was found in ward round notes when people had been labelled as lacking mental capacity, or a statement said simply the patient had 'no capacity to make decisions.' We found decisions recorded by medical staff in ward round notes to provide covert medication, but these were not accompanied by appropriate mental capacity assessments and best interest decision making processes.
- Several different styles of mental capacity assessments were seen in care records. None of the assessments provided rationale for the actual judgement as to the patient's mental capacity and none were decision specific. We found assessments which had been crossed out and over written with the phrase, 'Patient on Section 2 OF Mental Health Act'. The detention of a patient under the Mental Health Act does not supersede the need to assume mental capacity for all decisions.
- We identified a difference of clinical opinion as to a patient's mental capacity to consent to treatment and medication in their care records. This was raised with the ward manager on Shackleton ward at the time of our visit.

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- Staff told us that they had not received MCA training in some time. Mandatory training records provided by the trust for Afton and Shackleton ward revealed that only one member of staff had completed the e-learning training module which covered the MCA. The ward manager confirmed our findings, and stated that they had identified and acknowledged, internally within the ward's staff team that they were failing to meet the requirements of the Act.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- We observed at both wards visited that staff were respectful and supportive to their patients, and responsive to their needs. Senior staff spoken with corroborated our findings and stated that they felt the staff were genuinely kind and compassionate towards the people in their care. The patients we spoke with all spoke positively of the care and support they received from ward staff, and said that their doctors were caring and listened to them. One patient on Afton ward told us how the ward was providing free car parking passes for his friends and family, to enable them to visit.
- Staff team meeting minutes for Shackleton ward recorded that there had been some specific criticism of certain staff behaviours several months earlier, but that steps had been taken to address any issues with the individuals concerned. We observed only positive staff interaction with patients during our visit. For example, on Shackleton ward we saw staff acted gently and professionally when interacting with patients; getting down to the patients' level when speaking with them, and talking through what they were doing when administering medication. Similarly, we observed good rapport and positive interactions between patients and staff on Afton Ward.

The involvement of people in the care they receive

- We saw insufficient evidence to demonstrate that patients were fully and effectively involved in their own care. One patient on Afton ward had seen their care plan, but they had asked for this to be facilitated after they had not been provided with a copy. Other patients were unable to remember if they had seen their care plans, but were aware of their care being discussed on ward round with their doctors. We saw limited evidence of care plans being signed off by patients or of the patient's voice being reflected. Staff told us that independent advocacy was available to support patients and leaflets for independent advocacy services were displayed on both wards, but we found limited evidence of the involvement of advocates in people's records. On Afton ward we were shown a 'this is me' document which they were in the process of introducing for all patients. This would have additional personalised information about patients, from key relatives, and provide such details as a person's history, background, their likes and dislikes.

Are services responsive to people's needs?

Inadequate

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

Our findings

Access, discharge and bed management

- We found there were significant problems related to the availability of specialised dementia places on the island. Although this was largely beyond the control of ward staff, it was impacting directly on the care they were able to provide. Many of the patients on Shackleton ward had come onto the ward from care or nursing homes on the island which had been unable to care for them any longer when their condition had deteriorated. These were patients with advanced dementia, who were unable to be returned to their home due to complex care needs and challenging behaviour. Staff told us there was a wider problem with a lack of appropriate placements in residential and nursing care places on the island, which meant there was often nowhere else to discharge the patients to. This, in effect, meant that the seven beds on Shackleton were generally occupied by long-term patients.
- Because the beds on Shackleton ward were occupied long-term, increasingly, people with dementia were being admitted to Afton ward. This was causing difficulties with the patient mix. Afton ward is primarily for older adults with functional mental illnesses, such as schizophrenia, depression, mood disorders and anxiety. Staff on Afton ward told us the presence of increasing numbers of patients with dementia was proving to be very unsettling and disruptive to the functional patients the ward was designed primarily for. It was also having an impact in potentially restricting the free movement of functional patients. For example, patients' bedrooms were being locked at the time of our visit, to prevent other patients from accessing them after one patient with dementia had wandered into and urinated in another person's bedroom.

The facilities promote recovery, comfort and dignity

- We found that neither of the wards visited was an appropriate environment for effectively promoting the recovery, comfort and dignity of patients. On Shackleton ward, there were no curtains, blinds or other appropriate coverings on six of the seven patient bedrooms. There were also no coverings on the windows of the female lounge or seclusion room. This meant that patients in any of those rooms were potentially entirely visible to the general public in the busy public areas directly outside the ward. There was a clear and immediately identifiable risk that people would potentially be able to see personal care taking place, patients in states of undress, and patients in states of distress and agitation. The lack of window coverings also meant that patients would have to endure light coming into their bedrooms from the floodlit car park outside the ward at night time, and would have daylight entering their rooms at daybreak each day. The lack of appropriate window coverings clearly compromised the privacy, dignity and effective care of the patients on Shackleton ward. However, staff were aware of the issue and raised it with us as being something they were deeply unhappy about. Senior managers were aware of the issue, and minutes from a ward meeting in July 2016 recorded that there internal discussion had taken place at the trust as to where the money to fund the window coverings should come from. It was stated that the trust's estates department had no budget to fund the work, and also that the ward's budget didn't allow for the purchase. We raised this issue, along with other concerns about the environment, directly with the trust's most senior managers at the time of our inspection and in our subsequent S31 enforcement notice. When we revisited the wards on 18 and 19 January 2017 we found that blinds had been fitted to all of the bedroom windows. Staff spoken with said this had greatly improved the privacy and dignity of patients, and also that patients were now sleeping better at night.
- Similarly, the bedroom doors on Shackleton had observation windows which allowed visitors to the ward to see directly into patients' bedrooms. Staff had taken steps to mitigate the issue with the observation panels, and had provided coverings for the windows which a member of staff had made themselves.
- On Afton ward, we also identified problems with the environment that compromised patients' privacy, dignity and confidentiality. At the end of one corridor, a seating area with large windows was overlooked by the public car park. There were no window coverings, meaning that people were able to see straight in to the ward at this point. Staff confirmed that there had been instances of people looking in and seeing patients distressed. The nurses station, based in the centre of the ward, was open to the ward, without doors or ceiling. Staff raised with us that this presented significant

Are services responsive to people's needs?

Inadequate

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

challenges to maintaining patient confidentiality. Managers told us that major works were planned to take place early in 2017 to address this specific concern. When we revisited the wards on 18 and 19 January 2017 we found that curtains had been fitted to the windows in the seating area, which allowed for greater privacy from the adjoining public car park if patients chose to close the curtains. In addition, the glass in the door to the outside in this area had been made opaque.

- Shackleton ward was for elderly patients with organic mental health conditions, many of whom were infirm and had limited mobility. Despite this we found there was a lack of assistive technology, other than a hoist over the bath, and little else to aid patient mobility. Although bathrooms had rails, there were no raised seats or adapted toilets. There was little dementia friendly signage to aid patients' negotiating the environment. There was inadequate space for therapies and activities, and the majority of activities took place in the main seating area at the corner centre of the L-shaped ward. One lounge had been turned into the de-escalation / seclusion room. The remaining female lounge was starkly decorated and furnished. The outside space was not connected to the ward but down one storey and along a public corridor away from the ward, so was unsuitable for the needs of patients and of limited value. We saw little evidence that bedrooms were personalised according to the wishes or in line with the interests of individual patients. There was a lack of materials to aid reminiscing. Overall, the environment felt cold and overtly clinical.
- Afton ward had only one assisted bath available for patients to use. This meant patients did not have access to an ordinary bath, which would have helped to promote independence and recovery. Similarly to Shackleton ward, Afton had no dedicated occupational therapy room or space for activities, so the majority of activities took place in the main central communal area of the ward. We observed the majority of staff interactions with patients occurred in this main area, as did dining due to a lack of dedicated dining area. Afton ward did have more comfortable sitting areas and different areas where patients could access some private space. Patients had direct access to a garden space, which was connected to the ward. Due to poor design, layout and maintenance, this space was not safe for patients' use at the time of our visit. In addition to the safety issues detailed earlier in the report, poor design and maintenance meant there were multiple trip and fall hazards, which presented additional risks to elderly and infirm patients and prohibited patients' free access to the space.
- Staff at both wards were aware of many of the problems with the physical ward environments and raised their own frustrations and concerns with us during our visit. Despite limitations with the physical environments and other pressures such as staffing, staff tried hard to provide meaningful activities for their patients. On Shackleton ward staff showed us the activities cupboard, which contained games and craft materials. They told us they tried to provide activities seven days a week and also to spend individual one-to-one time with patients; for example, spending time looking at pictures of trains with a person who loved trains. Staff told us that when staffing allowed it, they took patients out for walks in the grounds each or every other day.
- Patients on Afton ward told us they wanted more things to do. An occupational therapist visited the ward on Friday mornings. The ward had a support worker who co-ordinated activities for three days a week. Patients told us these activities included board games, singing and reading newspapers. One patient told us that on the four days a week when no co-ordinator was available, they had little to do and so sat around a lot. Staff told us that they supported activities such as playing board games when they could. During our inspection visit the co-ordinator was not in work and most patients were either in their rooms, watching television or reading the paper. Patients told us there was no computer, Wi-Fi or access to social media to allow them to keep in contact and up to date with family and friends.
- Hot and cold drinks were available to patients on both wards throughout the day, but patients on Shackleton ward generally had to ask staff if it was outside of set drinks round times. We observed staff asking patients if they would like drinks throughout our visit. On Afton ward, patients who were risk assessed and supervised were also able to use a kitchen in support of their independence and rehabilitation. Although we didn't observe patients using the kitchen during our visit, it was recorded in ward meeting minutes from July 2016 that staff were to encourage patients to make their own drinks without restriction during the day.

Meeting the needs of all people who use the service

Are services responsive to people's needs?

Inadequate

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

- Leaflets containing information on different conditions, local independent advocacy and other additional support available, were displayed in prominent positions on the wards. Ward managers confirmed they were able to access information leaflets in different languages and formats if needed. They also had access to a list of staff across the site who spoke different languages, which was a resource they could access to support communication with patients for whom english was not a first language. Staff told us that they were able to cater for all specific diets and food requirements; including for those with specific cultural or religious needs and for people with medical dietary requirements. Patients from Afton ward were able to visit regularly the hospital chapel, in support of their spiritual needs.

Are services well-led?

Inadequate

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

Our findings

Vision and values

- Staff on both wards expressed a sense of disconnect between themselves, the wider trust and the senior management team. They spoke also of the pressure on them to maintain and drive up quality whilst funding for services was being cut. Although staff knew who the senior management team were, they felt they had only very rarely visited the wards. Staff were unclear as to the trust's vision and values, and cited regular changes in focus as contributing to that lack of clarity. These factors contributed to a sense among staff spoken with that mental health provision was not a priority for the trust.

Good governance

- The majority of staff across the two wards were up to date with their mandatory training. However, supervision was infrequent and had only recently been started up again on Shackleton ward. We were not assured that shifts were covered by sufficient numbers of staff of the right grades and experience for the acuity of patients. An earlier safer staffing pledge had not been realised, which left both wards down on assessed nursing staff levels. Several staff vacancies had not been filled on Shackleton ward, which contributed further to the pressures on that ward, although wards were able to bring in additional bank staff to cover some of the shortfall.
- As reported above, we identified failings in relation to the recording and reporting of incidents. We found that potentially poor and inaccurate recording and reporting of incidents meant that the provider could not be assured that incident data was accurate and reflected the actual number or detail of incidents, or the current risks within the service. It also meant that potential trends or near misses might not have been identified.
- We identified multiple concerns about the safety and fitness for purpose of the environment at both Shackleton and Afton wards. Information supplied to us by the trust following our inspection showed that the trust did not at that time have the necessary systems and processes in place to identify effectively such concerns. This in turn mean they did not have plans to effectively address many of the risks and concerns we identified. When we revisited the trust on 18 and 19 we saw evidence that the trust had started to make the necessary changes to its own governance systems and processes. Oversight meetings had started and took place every other day, involving relevant key parties from across the trust, so that they were able to monitor closely the plan and support the improvement works taking place. Fortnightly meetings with ward managers, health and safety and estates teams had commenced, to ensure work was being progressed and that risk was fully considering when prioritising work. Ward staff confirmed there was lots happening at the trust since our initial visit, including work to improve the internal governance systems.
- Staff had the ability to submit items to the trust risk register, and staffing and ward furnishings were given as examples of entries made by staff. Ward managers told us they got quarterly reports key performance indicators such as incidents, use of restraint, falls, and pressure ulcers.

Leadership, morale and staff engagement

- According to figures supplied to us by the trust, permanent staff sickness was at just over 4% on Afton ward and just over 7% on Shackleton ward. These were not particularly high rates when compared against the trust's other services. On a local level, staff and ward managers felt their immediate managers supported them well. Staff told us their teams were cohesive, and colleagues were described as welcoming and supportive. Ward managers told us they had regular contact with the clinical quality and safety lead. They also felt they were well supported by their line manager, the head of operations.
- Ward staff told us they felt comfortable raising their concerns or speaking up, without fear of recrimination or victimisation, if they thought improvements to services were needed. However, they told us morale had been badly affected because although there were regular staff surveys for them to feedback and though which and they had raised their concerns about key issues - including the ward environments and staffing - little or no action had been taken in response. The front-line staff we spoke with expressed their concern and sadness that there were significant issues that adversely affected the care and treatment they were able to give to their patients, despite their best efforts, which they felt were not being addressed at a senior level. Further, they thought the situation was deteriorating and

Are services well-led?

Inadequate

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

referred to feeling increasingly disempowered. Similarly, clinical staff felt there was insufficient understanding, at a senior trust management level, of mental health and the pressures the services were under.

- When we revisited the wards on 18 and 19 January 2017 staff spoke positively about how mental health now seemed a higher priority. Staff told us that they felt more involved and included by the trust's managers, whom they felt were listening to them and engaging openly with them in respect of improvements taking place.

Commitment to quality improvement and innovation

- Staff told us that there had been structured quality improvement work carried out previously to try to meet the Royal College of Psychiatrists accreditation for inpatient services (AIMS) standards for acute inpatient services for older people. Staff acknowledged that, as there were insufficient psychological and other therapies and significant work required with care plans and the physical environment, these standards could not be met.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken necessary steps to ensure care and treatment of all service users was appropriate, met their needs reflected their preferences. They could not demonstrate that they had: carried out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user; designed care or treatment with a view to achieving service users' preferences and ensure their needs are met; enabled and supported relevant persons to understand the care or treatment choices available to the service user. They had not enabled and supported the relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the maximum extent possible. This is a breach of regulation 9 (1)(a)(b)(c) & (3)(a)(b)(c)(d)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not ensured that service users were treated with dignity and respect. The environments on both wards did not ensure the privacy of service users at all times. This is a breach of regulation 10 (1) & (2)(a)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Requirement notices

The registered person had not ensured that the Care and treatment of service users was only provided with the consent of the relevant person. Where the the service user was 16 or over and unable to give such consent because they lacked capacity to do so, the registered person had not acted at all times in accordance with the Mental Capacity Act (2005).

This is a breach of regulation 11 (1) & (3)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person did not demonstrate that they had fully assessed all the risks related to the health and safety of service users receiving care or treatment and had not done all that was reasonably practicable to mitigate those risks. They had not ensured the premises were safe for their intended purpose and used in a safe way. Risks associated with the physical ward environment, such as ligature points, had not been fully assessed and addressed. The registered person had also not ensured that persons providing care or treatment to service users had the competence and skills to do so safely at all times, as some staff had not received training to be able to safely manage patients who were physically aggressive. They did not have all the necessary systems and processes in place for the proper and safe management of medicines. This is a breach of regulation 12(2)(a)(b)(c)(d)(g)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have the necessary systems and processes in place to effectively assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. They did not have the necessary systems and

This section is primarily information for the provider

Requirement notices

processes in place to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This is a breach of regulation 17 (1) & (2)(a)(b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the provision of the regulated activities. They did ensure all staff received such appropriate support, training, professional development and supervision as was necessary to enable them to carry out the duties they were employed to perform. This is a breach of regulation 18 (1) & (2)(a)

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. We issued a s31 Notice of decision to urgently impose conditions on the registered provider as we had reasonable cause to believe a person would or may be exposed to the risk of harm unless we did so. The notice was in respect of the provider, the Isle of Wight NHS Trust, and covered failings identified at a number of the provider's core services. In respect of the provider's mental health inpatient services, including its wards for older people with mental health problems, we said the following in that notice: **G.** The registered provider must carry out an urgent assessment of the physical environment on the inpatient mental health wards at St Mary's Hospital. The trust must ensure there are a comprehensive ligature assessment and an action plan to mitigate the risks. The action plan must include a stated time for completion. The assessment must cover all inpatient mental health wards and environments. There should be effective leadership, and the necessary resources and support to ensure changes have appropriate governance, are appropriately supported and are implemented with the necessary pace and urgency. The action plan must be produced by Wednesday 28 December 2016. **H.** The registered provider must immediately review its policy and procedures and governance arrangements to ensure there is appropriate assurance to identify, assess, manage, mitigate and monitor all environmental risks to patients' care and safety across all inpatient mental health services. This includes where patient privacy and dignity may be compromised. The governance arrangements need to identify where additional resources and support are required and how staff will be

This section is primarily information for the provider

Enforcement actions

supported to understand what actions need to occur to effectively manage all environmental risks. The trust must provide a copy of the revised governance arrangements by Wednesday 11 January 2017.

I. The Registered Provider must ensure that the Commission receives the following information every two weeks.

- A risk register that includes all environment risks in inpatient mental health services
- The action(s) taken to mitigate the risks
- Risks mitigated through individual patient assessment
- The controls that are in place
- The ongoing dated review and specified actions of how these risks are being managed.