

Requires improvement



Isle of Wight NHS Trust

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

## Quality Report

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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)
R1FX7	Sevenacres (Inpatient Wards)	Seagrove Ward	
R1FX7	Sevenacres (Inpatient Wards)	Osbourne Ward	

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

Requires improvement



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



### 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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# Summary of findings

## Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- Both wards had multiple ligature risks. We were concerned to learn that there had not been a full comprehensive assessment of ligature risks on either ward since 2012. An assessment had been completed that focused only on some risks and did not contain information relating to the mitigation of risks or levels of severity. There was no oversight or ownership by immediate and higher management about the ligature risks on either ward.
- As a result we issued a notice under Section 31 of the Health and Social Care Act 2008. We asked that the trust ensure that a comprehensive ligature assessment and an action plan to mitigate the risks be completed and produced by Wednesday 28 December 2016.
- In addition, we issued the trust with a Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 notice. This notice required the trust to respond within 28 days of receipt because of the following findings:
- Osbourne ward held responsibility for the crisis service out of hours. This impacted on the ward staff being able to undertake safely their core ward duties. Although overall morale was high, staff on Osbourne ward described feeling stressed and unable to do their ward duties safely due to the additional demand placed on them by the crisis service. We were also concerned to learn that Osbourne ward admitted patients beyond their 19 bed capacity. Osbourne ward will admit up to 21 patients by using an interview room and a male lounge as bedrooms. Bedrooms on both wards shared interconnecting bathrooms. On Seagrove ward men and women would have to share the same bathroom if they occupied the adjoining

bedrooms, although staff told us if this occurred they would restrict the men having access to the bathroom by locking the doors. In addition, each patient could access the other patient's bedroom without being seen by staff. Although the trust had called engineers in to look at the personal alarm system, the system on both wards did not work properly and failed on occasion to sound when activated and lead staff to the correct area where incidents were occurring. Patient care plans on both wards were incomplete and on occasion missing. Care plans were not patient centred, personalised, holistic or goal orientated. Some information relating to physical health assessments was missing.

In addition we found that:

- The seclusion room on Seagrove ward did not allow for free access to the toilet and shower. In order for patients who were secluded to use these facilities, seclusion would have to end. In the event that this was not possible, disposable apparatus for elimination purposes were provided in the seclusion room. In addition, some medical devices on Seagrove ward had not been tested in the past 12 months.
- Rapid tranquilisation of patients was not being done in line with national guidance and legislation. Not all safeguard incidents were reported correctly. Adherence to statutory and mandatory training did not meet the required level in all areas.
- The reception area at Sevenacres, before you entered the ward areas, was dirty and there was an unpleasant smell.
- Staff we spoke with described a disconnect from the trust board. Staff told us that trust board representatives rarely visited the wards.

# Summary of findings

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

### Are services safe?

We rated acute wards for adults of working age and psychiatric intensive care units as inadequate because:

- Both wards had multiple ligature risks. There had not been a full comprehensive assessment of ligature risks on either ward since 2012. An assessment had been completed that focused only on some risks and did not contain information relating to the mitigation of risks or levels of severity.
- Bedrooms shared interconnecting bathrooms. On Seagrove ward, men and women would have to share the same bathroom if they occupied the adjoining bedrooms, although staff told us if this occurred, they would restrict the men having access to the bathroom by locking the doors. In addition, each patient could access the other patient's bedroom without being seen by staff.
- Osbourne ward held responsibility for the crisis service out of hours. This affected the ward staff being able to undertake safely their core ward duties.
- The seclusion room did not allow free access to the toilet and shower. In order for patients being secluded to use these facilities, seclusion would have to cease. In the event that this was not possible, disposable apparatus for elimination purposes were provided in the seclusion room.
- Rapid tranquilisation of patients was not being done in line with NICE and Code of Practice guidance.
- The reception area, before you entered the ward areas, was dirty and had an unpleasant smell.
- Some medical devices had not been tested in the past 12 months.
- The personal alarm system on both wards not did work properly and failed on occasion to sound when activated and or lead staff to correct area where incidents were occurring.
- Adherence to statutory and mandatory training was did not meet the trust standard.
- Not all safeguard incidents were reported.

However:

- Staffing levels were good with few vacancies.
- There was learning from incidents and information was cascaded to staff through a number of different methods.

Inadequate



# Summary of findings

## Are services effective?

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- Patient care plans were incomplete and on occasion missing. Care plans were not patient centred, personalised, holistic or goal orientated. Some information relating to physical health assessments was missing.

However:

- Risk assessments and risk management plans had been completed.
- There was access to a range of professionals on the ward. Staff were skilled and experienced. Some nurses were trained in cognitive behaviour therapy (CBT) and dialectic behaviour therapy (DBT).
- Detention paperwork was in place and up to date. Patients had their rights read routinely and regularly. Staff worked in line with least restrictive principles. Mental Health Act training across both wards was 90%.
- Supervision and appraisal rates were good.

**Requires improvement**



## Are services caring?

We rated acute wards for adults of working age and psychiatric intensive care units as good because:

- We observed interactions between staff and patients that were warm, good humoured, well-mannered and professional. Patients we spoke with talked fondly of staff and their experience on both wards.
- Staff went the extra mile to understand the experience of patients in seclusion.
- A carers meeting was held weekly for families and carers on Osbourne ward. Patients we spoke with told us that families were included in their care with their agreement.
- Staff showed good knowledge of individual patient needs.
- Regular community meetings and coffee mornings were held on both wards.

However:

- We found little evidence to show that patients had been actively involved in their own care and treatment plans, despite some patients stating to the contrary.

**Good**



## Are services responsive to people's needs?

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

**Requires improvement**



# Summary of findings

- Osbourne ward admits patients beyond their 19 bed capacity. Osbourne ward will admit up to 21 patients by using an interview room and a male lounge as bedrooms.
- Access to Seagrove ward was through Osbourne ward. This was disruptive to ward staff and patients on Osbourne. There were dignity issues relating to patients requiring access to Seagrove as quite often patients being admitted into PICU can be quite highly agitated and challenging.

However:

- There was always a bed on the psychiatric intensive care unit (PICU) if needed.
- There were no out of area placements. There had been two delayed discharges on Osbourne ward in the six months prior to our visit.
- Seagrove ward described how they would respond to patients with protected characteristics. Transgender patients would be placed in bed areas in line with the gender that they identified themselves with.
- There was a full range of rooms and equipment available to support treatment. Access to outside space was unrestricted. There was access to activities on and off the ward and at the weekend.
- Both wards facilitated the use of mobile phones.
- Patients told us that the food was of good quality. Patients with specific dietary requirement were catered for.
- There was a low level of complaints received across both wards. Patients told us that they knew how to complain. Information relating to the complaints process was on display.

## Are services well-led?

We rated acute wards for adults of working age and psychiatric intensive care units as requires improvement because:

- There was no oversight or ownership by immediate and higher management about the ligature risks on both wards.
- Although work had begun to address the poor quality of care planning, some patients were without care plans or had plans that were not meaningful, personalised and subject to regular review.
- Although overall morale was high, staff on Osbourne ward described feeling stressed and unable to do their ward duties safely due to the additional demand placed on them with regards to the crisis service.

**Requires improvement**



# Summary of findings

- Although staff described the ward managers and matron as supportive and visible, staff we spoke with described a disconnect from the trust board. Staff told us that they rarely saw trust board representatives visiting the wards.

However:

- Staff were supportive of each other and there was a good sense of team work and camaraderie.



# Summary of findings

## Information about the service

Osbourne and Seagrove ward are both located on the St Mary's Hospital site, in the Sevenacres building, on the Isle of Wight.

Osbourne ward is a 19 bed acute admissions ward for men and women of working age. At the time of our visit the ward was fully occupied.

Seagrove ward is an eight bedded psychiatric intensive care unit. At the time of our visit, there were six patients on the ward, five of which were detained under the mental health act.

## Our inspection team

Head of Hospital Inspection: Joyce Frederick

Lead Inspector: Lisa McGowan

The team was comprised of: Two CQC Inspectors, one Mental Health Act Reviewer, one pharmacist and one assistant inspector.

## Why we carried out this inspection

We inspected this core service as part of a responsive follow up focussing on areas for improvements arising from last inspections and concerns from ongoing monitoring.

When we last inspected the trust in June 2014, we rated acute wards for adults of working age and psychiatric intensive care units good overall.

We rated the core service as good or safe, effective, caring, responsive and well-led.

## 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 acute wards for adults of working age and psychiatric intensive care units and requested further information from the trust. This information suggested that the ratings of good for safe, effective, caring, responsive and well led, that we made following our June 2014 inspection, were no longer valid. Therefore, during this inspection, we focused on all the areas we had concerns.

During the inspection visit, the inspection team:

- visited two wards at one hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with the managers for each of the wards
- spoke with eleven other nursing staff members
- interviewed the divisional director with responsibility for these services
- attended and observed one hand-over meeting

We also:

- looked at twelve treatment records of patients
- carried out a specific check of the medication management on both wards.
- looked at a range of policies, procedures and other documents relating to the running of the service

# Summary of findings

## What people who use the provider's services say

Patients we spoke to were very happy with the service that they received on both Seagrove and Osbourne ward.

Patients were very complimentary about the staff and their attitudes towards them.

## Good practice

- There were good relations with the local police force. One police constable would support staff and patients

whilst out on leave from the hospital, helping to ensure that leave occurred without incident or if an incident occurred that a quick response was had to deal safely with the situation.

## Areas for improvement

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

- Following the CQC issuing a section 31 notice to the trust, the trust must ensure that an immediate comprehensive assessment is undertaken of all the ligature risks on both Osbourne and Seagrove and that an action plan to minimise the risks is put in place. In addition, the assessment should be subject to regular and ongoing review and a ligature reduction plan formulated.
- The trust must ensure that where interconnecting bathrooms are used, that the locking mechanisms designed to maintain safety and privacy are in good working order. In addition, the trust must ensure that they are assured that the interconnecting bathroom arrangements are safe for patients to use.
- The trust must ensure that it reviews the out of hours crisis arrangements on Osbourne ward and ensures that adequate resources are available that do not impact on the ward staff.
- The trust must ensure that it reviews its bed management policy in relation to Osbourne ward and does not continue to use a 19 bedded facility for 21 patients without proper resources and space.

- The trust must ensure that care plans for patients are completed, present, subject to regular review, patient centred and goal orientated.
- The trust must ensure that staff have available to them attack alarms that are reliable and effective.
- The trust must ensure that all safeguard alerts are properly recorded and reported.
- The trust must ensure that all patients subject to rapid tranquilisation receive physical health monitoring checks in line with NICE guidance and Code of Practice legislation.
- The trust must review its current toileting arrangements for seclusion and ensure that patient's privacy and dignity is maintained when being secluded.
- The trust must ensure that all medical devices are subject to regular testing to ensure they are in good working order.

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

- The trust should review its patient record recording system and ensure that where they use two different systems (electronic and paper) that there are systems in place to ensure that both work effectively.

Isle of Wight NHS Trust

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

## Detailed findings

### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Osbourne Ward	
Seagrove Ward	

### Mental Health Act responsibilities

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

- We reviewed six patient files across both wards with regards to their detention under the Mental Health Act (MHA). All MHA paperwork had been subject to scrutiny upon admission.
- All six records showed evidence of patients receiving their rights on admission and routinely thereafter. All detention paperwork was filled in correctly, up to date and stored within the nursing office which was not accessible to patients.
- Paperwork that authorised leave were standardised and had conditions clearly written. Patients had signed the form however it was not clear if they had been given a copy of the form.
- Mental health act training across both wards was 90%.
- Staff we spoke with had a good understanding of the MHA, the code of practice (CoP) and its guiding principles.
- We saw evidence on both wards that patients had been informed of their right to see an independent mental health advocate (IMHA). We were told that the IMHA visited the ward weekly and that the ward had good links with the service. Patients told us they were aware of the IMHA service.

# Detailed findings

## Mental Capacity Act and Deprivation of Liberty Safeguards

### Good practice in applying the MCA

- We did not review any patient care records relating to the mental capacity act during this inspection. However patients we spoke with did tell us that they felt supported by staff to make decisions for themselves. Patients told us that they felt listened to and that their views were always taken on board by staff.
- The trust could not provide accurate information about how many staff had received training in this area.
- Staff we spoke with were familiar with the five statutory principles underpinning the MCA and spoke about the need to care for people under conditions of least restriction.
- The trust has a policy relating to the mental capacity act which staff could access.
- Staff were able to seek advice and support regarding MCA issues from a central office.
- There is a Band six nurse who is also a best interest assessor based on Seagrove ward.

# 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 environment

- Both wards were spacious, airy and light. Apart from two conservatory areas at either end of the ward, Seagrove had a clear view of the remainder of the ward without obstruction. Due to the location of the nursing station, Osbourne had reasonable view of the female corridor. The male corridor was further along the main area of the ward. However once staff were in this area there were clear lines of sight.
- Both wards had multiple ligature risks. There had not been a full comprehensive assessment of ligature risks on either ward since 2012. An assessment had been completed that focused only on some risks within the ward areas and did not contain information relating to the mitigation of risks or levels of severity. The courtyards on both wards had not been assessed. The courtyard on the Osbourne ward was vast with hidden areas that were not in view of staff. These areas contained fixtures that could be used to tie ligatures, for example piping and fencing. Internal doors that had exposed hinges and bar closures were not included on the assessment. One door had no anti barricade defences, which would restrict staff being able to access patients in the event of an emergency. This had not been highlighted on the assessment. We discussed these concerns with the ward managers and asked that a full and comprehensive assessment of ligature risks be completed as a matter of priority. Ligature cutters were available on both wards and all staff we spoke to knew where they were located and how to use them. In addition staff observed patients on a minimum hourly basis on both wards, increasing observation levels where necessary based on risk. We reviewed live observation records for the past 24 hours on both wards and all had been completed, indicating that patients were being checked by a nurse in line with care and treatment plans.
- Both wards were mixed sex and provided areas, including lounges and bedrooms that were gender specific. However bedrooms on both wards had interconnecting bathroom facilities between two bedrooms. The bathrooms sat in between two bedrooms and were accessed by each bedroom by separate doors that led from the bathrooms into the bedrooms and vice versa. In order to work effectively, patients are required to manage the use of these bathrooms. It was possible on Seagrove ward for one bathroom to be shared by a female and a male patient, although staff told us if this occurred, they would restrict the men having access to the bathroom by locking the doors. We were concerned that the current arrangement may impact on patient safety, proper and effective management of mixed sex environment and privacy and dignity issues.
- We were concerned to learn that Osbourne ward held responsibility for the crisis service out of hours between 1am hours and 7am in the morning. This could sometimes be from 10pm until 7am dependent on crisis staff availability. The ward was on occasion supported by the psychiatric liaison nurse whose primary duty was to assess patients presenting themselves at the adjacent accident and emergency department. Other than this, there was no additional staffing above base numbers to help respond to crisis calls from community patients. Staff told us that they felt unable to complete their core ward duties safely as they were often occupied with crisis calls for several hours at a time. Furthermore, there was no specific crisis training available and quite often, the management of crisis situations fell to Band 2 Health Care Assistants. The ward manager had escalated her concerns to the trust board and we saw evidence of this. We reviewed data relating to the amount of calls taken by the ward over the past 12 months. Each month the number of calls exceeded 100. October 2016 alone accepted 179 calls directly related to community patients in crisis.
- Not all safeguard events were reported properly. We identified safeguarding incidents that the ward staff had not reported to the local safeguarding team. This included patient on patient assaults. A staff member told us that they would not always report this type of incident, as the ward staff felt they were responsible for safeguarding the patients. We spoke to the ward manager who confirmed that staff should always report these types of incidents as safeguarding. The wards held no local record of ongoing safeguarding concerns, once

# Are services safe?

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a safeguarding alert and could not advise on the outcome of any alerts made. We were advised that there had been changes to the trust safeguarding procedures and now all safeguarding alerts went to the trust safeguarding lead.

- There were clinic rooms on both wards. Both contained emergency lifesaving equipment, all of which was present. Two suction tubes were out of date and the expiry date could not be read on a set of defibrillator pads. Emergency medicines, including oxygen were within their expiry date. The range of emergency medicines on both wards met national guidelines for mental health settings. We did however find medication in the treatment room on Osbourne ward that had not been locked in the drug cupboard and we did find some expired injectable medication in the fridge on Osbourne ward.
- The seclusion room on Seagrove ward allowed for clear observation and two-way communication. The toilet and shower were located in the same vicinity as the seclusion room, was exclusively for use by patients in the seclusion room but could not be accessed from the seclusion room itself. The patient had to step outside of the seclusion room to use the toilet, increasing the risks to themselves and others when doing so. Therefore in order for patients to use the toilet or the shower, seclusion had to be ended. Where this was not possible due to risks being present, staff provided the patient with disposable utensils. We were concerned about the impact these arrangements had on the privacy and dignity of patients.
- Both wards were clean, well maintained and had good furnishings. However, the reception area of Sevenacres, before entry to the wards, was dirty. There was a slight unpleasant odour. The site managers told us that a total refurbishment was due to start and would be addressing areas in poor condition.
- Both wards were clean and tidy and cleaning records were up to date. However some bedrooms we entered were had an unpleasant smell. These bedrooms were occupied at the time by patients in the acute stages of psychosis and staff told us that they required additional support with personal care. However, vacated bedrooms had been cleaned and were free of odours.

- Staff adhered to infection control principles. There was signage placed around the ward instructing how to wash hands correctly. We observed staff washing hands before and after contact with patients. Colour codes advise staff of which utensils to use in which area.
- On Seagrove ward, the sphygmomanometer and electro cardiogram machine had not been calibrated or portable appliance testing (PAT) tested in the past 12 months. The Blood monitoring machine which is required to be calibrated every day prior to use had not been done in the past three days.
- Environmental risk assessments are undertaken annually and we saw records to show that this was the case. This included health and safety matters, Infection control issue and control of substances hazardous to health (COSHH).
- Staff told us that the personal alarm system was ineffective and did not work properly. Alarms would malfunction, would at times not sound when activated and lead staff to the wrong areas potentially placing patients and staff at increased risk of harm. Staff told us that this had been an issue for at least the past two years. Seagrove ward had purchased personal alarms for staff from a local shop. Although the trust had recently called in engineers to look at the personal alarm system, we brought this to the attention of the trust at the time of our visit.

## Safe staffing

- Both wards were well staffed with few vacancies. As of October 2016 Seagrove had one registered mental nurse (RMN) whole time equivalent (wte) vacancy and one health care assistant (HCA) wte vacancy. Osbourne ward had one HCA wte vacancy and no RMN vacancies.
- Both wards ran a three-shift system and would have five staff on during the day and four staff on at night on both wards. Both wards aimed to have two registered mental nurses on at any one time.
- As of October 2012, both wards reported sickness levels as being 5%.
- In the month of October Osbourne ward covered 81 shifts with bank and agency staff due to sickness, leave and clinical demand. Bank and agency staff had covered 52 for the same month on Seagrove ward. Ward managers told us that they always tried to use bank and agency that were familiar to the wards.



# Are services safe?

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- Both ward managers told us that they felt able to adjust staffing levels to meet clinical demand without question from senior staff.
- Staff on both wards told us that patient leave was rarely cancelled due to low staff numbers. If this did occur, staff told us that leave would be rearranged.
- Both wards accessed the on call duty system when requiring medical staff and senior support out of hours.
- Across both wards mandatory training overall was 83%. Safeguarding adults and children level two, people handling, adult resuscitation, disability awareness and fire safety part two were all below 75%. Physical intervention training was 77%. Load handling, paediatric resuscitation and safeguarding children level three were all 100%.

## Assessing and managing risk to patients and staff

- Between April 2016 and September 2016 Seagrove ward reported 23 incidents involving the use of seclusion. Of these, none were under conditions of long-term segregation. For the same period, Seagrove ward reported 41 incidents involving the use of restraint, 13 of which had involved the same patient. Seven of these were reported as being in the prone position, four of which required rapid tranquilisation. For the same period, Osbourne ward reported two episodes involving the use of seclusion and 22 incidents involving restraint, ten of which involved the same patient. Osbourne ward reported no use of prone restraint or rapid tranquilisation.
- Care records we reviewed showed that all patients had received a risk assessment on admission, which had been subject to review and update thereon.
- On Seagrove ward patients were able to smoke on the hour every hour. Access to the courtyard was not restricted as a consequence. Both wards allowed free access to hot drinks and snacks however, both wards would restrict access to these facilities in the event of a serious and risky situation. However, this would be a temporary measure until the ward was settled again.
- Upon admission to the ward all patients were given welcome packs which contained information about the ward, including how to leave if a patient was informal.
- The trust had an observation policy in place. We reviewed records relating to patient observations during our visit and found that on both wards patients were being observed by staff on a minimum hourly basis. Seagrove ward conducted daily room searches in order to locate any contraband items. However, staff told us that patients are not subject to searches upon their return from leave or other activity away from the ward.
- Staff told us that restraint is only used after de-escalation had failed and we found no evidence whilst talking to patients or reviewing care records to demonstrate otherwise.
- On Seagrove ward we reviewed two cases where patients had been subject to rapid tranquilisation (RT). Both showed a lack of adherence to the national institute of health and care excellence (NICE) guidance when administering medicines required to bring about the rapid sedation of patients. NICE and the Code of Practice (CoP) both indicate that patients should be subject to regular physical health monitoring post RT administration. Both records did not demonstrate this.
- We reviewed one care record relating to the use of seclusion and found all to be in order. All necessary checks and reviews had taken place in line with CoP requirements. Records relating to seclusion were in a paper format and were stored within the nursing office.
- We reviewed ten medication cards across both wards and found no errors or omissions in recording. Controlled drugs were stored, recorded and handled appropriately. Spot checks on balances showed that contents of the cupboard matched the register. Medicines were within their expiry dates. Medicine waste was disposed of correctly.
- Staff were able to verbalise their understanding of safeguarding procedures and provide examples of when they would raise an alert. Staff drew our attention to a flow chart that was available to guide staff on what action to take when a safeguard event occurred. Safeguarding adults training across both wards combined was 64%. However we identified safeguarding incidents that the ward staff had not reported to the local safeguarding team. This included patient on patient assaults. A staff member told us that they would not always report this type of incident, as the ward staff felt they were responsible for safeguarding the patients. We spoke to the ward manager who confirmed that staff should always report these types of incidents as safeguarding. The wards held no local record of ongoing safeguarding concerns, once a safeguarding alert and could not advise on the

# Are services safe?

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

outcome of any alerts made. We were advised that there had be changes to the trust safeguarding procedures and now all safeguarding alerts went to the trust safeguarding lead.

- Child visit for both wards took place in a dedicated space off the ward elsewhere in the building. All child visits were supervised.

## Track record on safety

- Osbourne ward experienced one serious incident in the past two years, involving a death of a patient. There were no serious incidents on Seagrove ward in the past 12 to 24 months.
- Because of the serious incident, the staff had reviewed the observation policy and embedded it in working practice. New tamper proof windows had been installed throughout both wards.

## Reporting incidents and learning from when things go wrong

- The trust used an electronic incident reporting system called 'Datix'. All staff we spoke with were familiar with this system and provided examples for when they had used it to report incidents.
- Although not all staff were familiar with the term duty of candour, once explained all were able to explain its importance and provide examples of when they have been open and transparent with patients when things have gone wrong.
- Staff we spoke with told us they receive feedback from investigations by way of email, face to face meetings with managers, debrief and through staff meetings. Staff described a newsletter called 'Friday flame' that is disseminated by the trust and details information relating to incidents and subsequent learning points. Access to psychological support is also on offer for staff following any incidents.
- Staff were able to provide an example following serious incident of how communication had improved between varying levels of trust staff.



# Are services effective?

Requires improvement 

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

- The trust ran a paper and electronic system relating to care records. Electronic records were password protected. Paper records were kept within the ward offices, which were not accessible to patients.
- We reviewed fourteen care records in total with regards to care planning. None were able to demonstrate full adherence to personalised, recovery orientated plans of care. Some care plans had not been subject to regular review and in one case; there were no care plans present, despite the patient having been an inpatient on the ward for three weeks. Ward managers told us that care plans were a concern and that the service was taking action to address the concerns through audit, supervision and a redesigned care plan template. There was a working group to support these changes. However, there was no evidence of change or improvement having taken place.
- We reviewed fourteen care records and all had a completed risk assessment on admission or soon after. Staff had completed risk management plans and were documented them on the electronic record called 'Paris'. However, as the trust was using two different record keeping systems (paper and electronic), it was difficult to track how the information from one system to another related. Staff had not transferred identified risks onto the care plan records held within the paper-based system.
- We reviewed six care records across both wards with regards to physical health assessments being completed on admission. Although two had been thoroughly completed five were incomplete and were missing information for example, bloods and physical intervention information.

### Best practice in treatment and care

- Medication was prescribed in line with NICE guidance. For example, medication was prescribed in line with the recommended doses and was appropriate for the condition in which they were intended.
- Cognitive behaviour therapy (CBT) and dialectic behaviour therapy (DBT) were available to patients.

- Staff offered mindfulness sessions every morning to patients on Osbourne ward. This involved relaxation and breathing techniques. This was popular amongst patients who now request the sessions in the evenings too. Staff described the positive impact this has had with regards to anxiety and agitation, suggesting that it has decreased the amount of PRN medication that is being used. Seagrove ward also did mindfulness sessions during their coffee mornings.
- Access to podiatry, physiotherapy, tissue viability and dietetics was through the trust. Dental care was sourced locally.

### Skilled staff to deliver care

- Both wards had access to a range of health care professionals including medical staff, occupational therapists, psychologists and pharmacists.
- Staff had the necessary qualifications to do their job. Staff were experienced in health care and took pride in what they did.
- Staff received a corporate induction when starting employment with the trust. In addition, staff received local inductions to the ward and were given supernumerary time to familiarise themselves with the ward environment, policies and procedures.
- Qualified staff had received mentor and preceptorship training and some nursing staff were trained in cognitive behaviour therapy (CBT).
- Staff we spoke with told us that they receive regular supervision and an annual appraisal. All were very complimentary about the support and leadership they receive from the ward managers. As of October 2016, records showed that overall 94% of staff had received supervision on Osbourne ward. As of October 2016, records showed that overall 100% of staff had received supervision on Seagrove ward.
- Records showed that 89% of staff had completed an annual appraisal in the last year on Osbourne ward. Seagrove ward had completed 70% staff appraisals in the past 12 months.
- Neither ward had any staff that were subject to performance related monitoring. However, both ward managers were able to describe how they would manage staff whose performance was below the expected standard.

# Are services effective?

Requires improvement 

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.

## Multi-disciplinary and inter-agency team work

- Ward rounds were held across both wards weekly. A range of professionals, including, nurses, medical staff and psychologists attended these.
- The trust ran a three-shift system. At the beginning of each shift, nursing staff received a handover. In addition both wards held a morning multi-disciplinary meeting each week day where patient information and activity were shared, risks discussed and ward resources considered. We observed one of these meetings, which was informative and professional.
- Both wards described good relations with other teams including crisis and community mental health teams. However, some staff we spoke with described difficulties securing care coordinator attendance at ward meetings.
- Both wards described good relations with the local police force. There were regular visits from one police constable, who would assist staff on escorted leave to ensure that the leave went ahead without incident.
- Both wards described reasonable relations with the local authority and knew whom to contact should they require information relating to safeguarding events or general social care queries.

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

- We reviewed six patient files across both wards with regards to their detention under the Mental Health Act (MHA). All MHA paperwork had been subject to scrutiny upon admission.
- Paperwork that authorised leave were standardised and had conditions clearly written. Patients had signed the form however it was not clear if they had been given a copy of the form.
- Mental health act training across both wards was 90%.
- Staff we spoke with had a good understanding of the MHA, the code of practice (CoP) and its guiding principles.

- We reviewed twelve medication cards in general and where applicable, all had attached relevant consent to treatment paperwork.
- All six records showed evidence of patients receiving their rights on admission and routinely thereafter.
- Staff had access to administrative support and legal advice regarding the MHA from a central team.
- All detention paperwork was filled in correctly, up to date and stored within the nursing office which was not accessible to patients.
- We saw evidence on both wards that patients had been informed of their right to see an independent mental health advocate (IMHA). We were told that the IMHA visited the ward weekly and that the ward had good links with the service. Patients told us they were aware of the IMHA service.

## Good practice in applying the MCA

- We did not review any patient care records relating to the mental capacity act during this inspection. However patients we spoke with did tell us that they felt supported by staff to make decisions for themselves. Patients told us that they felt listened to and that staff always took on board their views.
- The trust could not provide accurate information about how many staff had received training in this area.
- Between April 2016 and September 2016 there were no deprivation of liberty safeguard (DoLs) referrals made on either ward.
- Staff we spoke with were familiar with the five statutory principles underpinning the MCA and spoke about the need to care for people under conditions of least restriction.
- The trust has a policy relating to the mental capacity act which staff can access.
- Staff were able to seek advice and support regarding MCA issues from a central office.
- There is a band six nurse who is also a best interest assessor based on Seagrove ward.

# Are services caring?

Good 

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 interactions between staff and patients that were warm, good humoured, well-mannered and professional. Patients we spoke with talked fondly of staff and their experience on both wards.
- Staff we spoke with had a good understanding of patient needs. We discovered an example of excellent practice where the ward manager on Seagrove ward had sought to understand the experience of the patient whilst using seclusion. The ward manager had agreed to be secluded for several hours whilst they the patient observed them by acting into a nurse's role during a period of seclusion. Both shared their learning from the experience, which included having a deep clean and the seclusion room painted.

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

- Patients we spoke with told us that upon admission to both wards staff had introduced them to other patients and orientated to the ward environment.

- An external agency provided advocacy who attended the ward regularly and for relevant meetings such as ward rounds.
- There was a carers meeting for families and carers on Osbourne ward. Staff were able to offer an example of how these meetings had helped to alleviate the anxieties of one mother whose son or daughter had been admitted to the service. Patients we spoke with told us that families were included in their care with their agreement.
- Community meetings were held weekly on both wards. These were a forum for patients to share their views, experiences whilst on the wards, compliments and complaints. Seagrove ward held a coffee morning daily seven days a week. This meeting is used to plan the day's activities and allow patients opportunities to express concerns. This has proved popular amongst patients who have requested for evening social events of a similar nature.
- We found little evidence to show that patients had been actively involved in their own care and treatment plans. However, there were varying views from patients. Some stated that they had been involved and had copies of their care plans and others said they had not.

# Are services responsive to people's needs?

Requires improvement 

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

## Our findings

### Access and discharge

- We were concerned to learn that Osbourne ward admits patients beyond their 19 bed capacity. Osbourne ward will admit up to 21 patients by using an interview room and a male lounge as bedrooms. We brought this to the attention of trust board immediately due to reasons relating to health and safety of patients due to unsuitable sleeping arrangements (they were using converted communal spaces). In addition, the ward provided no extra staffing when patients were admitted beyond the wards usual capacity of 19 beds.
- Between April 2016 and September 2016 Osbourne ward reports bed occupancy levels as 84%. Seagrove ward reports bed occupancy levels at 89% for the same period.
- There were no out of area placements in the six months prior to our visit. Beds were available to patients living within the catchment area.
- Seagrove ward had no delayed discharges in the past six months prior to inspection. Osbourne ward reported two for the same period.
- Length of stay over the past 12 months prior to inspection averaged at 26 days on Seagrove ward and 14 days on Osbourne ward.
- Depending on the length of leave, beds were available for patients to on their return.
- The crisis team act as gatekeepers to the wards. Following assessment in the community, patients are admitted to the wards. Once admitted patients are subject to a further assessment by a designated assessment team. This team formulate a 72-hour care plan. This team are not ward staff.
- Patients were not transferred between wards during an admission episode unless there was justified reason based on clinical need to do so.
- The staff team did not discharge patients at inappropriate time of the day unless there was a clinical reason to do so.
- Osbourne ward confirmed that a bed was always available on Seagrove ward when required. Both ward managers worked closely with each other to support clinical demand and bed management issues.

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

- Seagrove ward described how they would respond to patients with protected characteristics. Staff placed transgender patients in bed areas in line with the gender that they identified with. Staff was supported this through increased use of observation, by providing staff with relevant information to raise awareness and educate as to the specific needs of these patients and by considering dignity issues during restraint.
- There was a full range of rooms and equipment available to support treatment. Adjacent to the wards and for use by both were occupational therapy facilities, including an assessment kitchen. Both wards provided space on the wards for art and other recreational activities, including board games, exercise and music.
- Visits were conducted in the main communal areas of the ward.
- There was access on both wards to a public pay phone. However, both wards provided use of a cordless ward phone. Osbourne ward allowed patients to use their mobile phones, asking that confidentiality is adhered to with regards to camera and audio phones. Seagrove ward allowed personal mobile use however, provided phones for patients that did not have a camera or audio recording capabilities.
- Both wards had access to the outside that was not restricted. If access to space was restricted due to risk, this would be a temporary measure and subject to review.
- Patients we spoke with told us that the food was of good quality.
- Generally, patients were able to make hot drinks and snacks without restriction. However the kitchen on Osbourne ward was locked after 11pm but on request after this time, patients could gain access.
- Patients were able to personalise their own bedrooms and we saw examples of artwork, and family photographs displayed in rooms.
- Both wards provided space where personal valuable possessions could be stored, which upon request, patient had access too.

# Are services responsive to people's needs?

Requires improvement 

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

- There was access to activities on and off the ward and at the weekend. For example, baking, stress and anxiety management, coping skills, music, creative expressions, well-being, gym sessions, art and crafts and a PAT dog visited weekly.
- Access to Seagrove ward was through Osbourne ward. This was disruptive to ward staff and patients on Osbourne. There were dignity issues relating to patients requiring access to Seagrove as quite often patients being admitted into PICU can be quite highly agitated and challenging.

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

- Both wards were easily accessible for patients with mobility issues due to ground level location. Corridors and bedrooms were wide and could easily accommodate wheelchairs or other equipment. There were assisted bathrooms on both wards.
- Information leaflets were available on both wards. Information leaflets in other languages were available to staff if required.
- Both ward displayed information relating to treatment, patients' rights, advocacy and how to make complaints.
- Access to interpreters or signers was available locally and when needed.

- The ward staff were able to meet the dietary requirements of religious and other ethnic groups on request to the catering department.
- A chaplain visited both wards regularly. Access to other religious representatives was by request and through the chaplain.

## Listening to and learning from concerns and complaints

- In the past twelve months prior to the inspection, both wards received one complaint. Seagrove ward upheld their complaint and Osbourne ward did not. Neither complaint was referred to the ombudsman. Both related to communication issues between staff and relatives of patients.
- In the same period, Seagrove ward had received a total of six compliments and Osbourne ward a total of three.
- Patients we spoke with told us that they knew how to make a complaint and where to seek support from in doing so.
- Staff we spoke with were able to show how they would support a patient in making a complaint and how they would respond when a complaint was brought to their attention.

# Are services well-led?

Requires improvement 

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

- All staff we spoke with told us that they worked in accordance with the organisation's values and that these reflected their own ward values.
- Staff we spoke with described a disconnect from the trust board. Staff told us that they rarely saw if at all, trust board representatives visiting the wards. Staff described the ward managers and matron as supportive and visible.

### Good governance

- Although both wards contributed to a trust risk register, which included risks relating to some ligatures on the wards, there was no oversight or ownership by the immediate managers or senior management of the ligature risks on both wards.
- Although work had begun to address the poor quality of care planning, some patients were without care plans or had plans that were not meaningful, personalised and subject to regular review.
- Although staff were verbalising their understanding of safeguarding events and the process they would take, not all safeguarding incidents were being reported.
- Supervision and appraisal rates were high. Staff were receiving statutory and mandatory training and although most areas were above 75%, some fell below this. MHA was 90% overall, however we were unable to obtain MCA training data from the trust.
- Complaint data showed a low level of complaints being made.
- The trust uses key performance indicators (KPI) to monitor team performance. These include seven-day follow up, staff sickness and delayed discharges.
- Seagrove ward had placed the lack of administration support on their local risk register. Both wards shared administration support; however, they predominantly supported Osbourne ward. Both ward managers felt that they had sufficient authority within their own wards.

### Leadership, morale and staff engagement

- Staff felt isolated as a service from the rest of the trust, stating that board members were not accessible or visible. Staff were very complimentary about the two ward managers and the matron. Staff recognised the good working relationship the three had together and were confident that if issues arose they would be dealt with swiftly and fairly.
- Staff on Osbourne ward expressed their concern related to the additional demands and workload created by operating the out of hour's crisis line on the ward. We saw evidence to show how the ward manager for Osbourne ward had escalated their concerns to the trust board, emphasising the risks to patient safety. All staff we spoke with felt they were not being listened to at the trust board level with regards to their concerns.
- Staff spoke fondly of each other and described good team relations across both wards, and across disciplines.
- There were no cases of bullying and harassment at the time of our visit and no one brought any to our attention.
- Staff we spoke with told us that they felt able to raise concerns with their line managers in line with the whistleblowing process without fear of victimisation.
- Staff we spoke to told us that opportunities for career development had become restricted due to funding.
- Staff were able to demonstrate their understanding of duty of candour and why it was important to explain to patients when things go wrong.
- Both wards reported sickness rates as 5% for the month of October 2016.

### Commitment to quality improvement and innovation

- Both wards had been the subject of a recent accreditation for inpatient mental health services (AIMS) review and were awaiting the outcome.



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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Osbourne ward held responsibility for the crisis service out of hours. This impacted on the ward staff being able to undertake safely their core ward duties.</p> <p>This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) and (2 a b c and d)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Rapid tranquilisation of patients was not being done in line with NICE and Code of Practice guidance. Physical health monitoring was not being undertaken in line with RT practice.</p> <p>This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) and (2 a b and g)</p>
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Both Osbourne and Seagrove wards had multiple ligature risks. There had not been a full comprehensive assessment of ligature risks on either ward since 2012. An assessment had been completed that focused only on</p>

This section is primarily information for the provider

## Requirement notices

some risks within the ward area and did not contain information relating to the mitigation of risks or levels of severity. The courtyards on both wards had not been assessed.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) and (2 a b and d)

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

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

Bedrooms on both wards had interconnecting bathroom facilities between two bedrooms. In order to work effectively, patients are required to manage the use of these bathrooms. We were concerned that the current arrangement may impact on patient safety, proper and effective management of mixed sex environment and privacy and dignity issues.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 (1) and (2 d and e).

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Osbourne ward admits patients beyond their 19 bed capacity. Osbourne ward will admit up to 21 patients by using an interview room and a male lounge as bedrooms. This arrangement has the potential to impact negatively on the health and safety of patients and staff.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1 c and d)



This section is primarily information for the provider

## Requirement notices

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

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

Patient care plans were incomplete and on occasion missing. Care plans were not patient centred, personalised, holistic or goal orientated. Some information relating to physical health assessments was missing.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (1 a, b and c) and (3 a and b).

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

During periods of seclusion, in order for patients to use the toilet or the shower, seclusion had to be ended. Where this was not possible due to risks, staff provided the patient with disposable utensils. We were concerned about the impact these arrangements had on the privacy and dignity of patients.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 (1) and (2 a).

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

On Seagrove ward, the sphygmomanometer and electro cardiogram machine had not been calibrated or portable appliance testing (PAT) tested in the past 12 months. The Blood monitoring machine which is required to be calibrated every day prior to use had not been done in the past three days.

This section is primarily information for the provider

## Requirement notices

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1 e)

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

The personal alarm system was ineffective and did not work properly. Alarms would malfunction, would at times not sound when activated and lead staff to the wrong areas potentially placing patients and staff at increased risk of harm.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1 c d and e).

### Regulated activity

Diagnostic and screening procedures  
Treatment of disease, disorder or injury

### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Not all safeguard events were reported properly. We identified safeguarding incidents that the ward staff had not reported to the local safeguarding team. This included patient on patient assaults.

This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 (1), (2) and (3).

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	<p>Section 31 HSCA Urgent procedure for suspension, variation etc.</p> <p>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 of decision was in respect of Isle of Wight NHS Trust.</p> <p>1. 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 is 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.</p> <p>2. 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 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.</p>

This section is primarily information for the provider

## Enforcement actions

3. 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.

Both wards had multiple ligature risks. There had not been a full comprehensive assessment of ligature risks on either ward since 2012. An assessment had been completed that focused only on some risks within the ward areas and did not contain information relating to the mitigation of risks or levels of severity. The courtyards on both wards had not been assessed. The courtyard on the Osbourne ward was vast with hidden areas that were not in view of staff. These areas contained fixtures that could be used to tie ligatures, for example piping and fencing. Internal doors that had exposed hinges and bar closures were not included on the assessment. One door had no anti barricade defences, which would restrict staff being able to access patients in the event of an emergency. This had not been highlighted on the assessment.