

Requires improvement**Isle of Wight NHS Trust**

Long stay/rehabilitation mental health wards for working age adults

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) |
|-------------|---------------------------------|---------------------------------------|--------------------------------------|
| R1F33 | Woodlands | Woodlands | PO33 4LP |

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?

Inadequate



Are services caring?

Good



Are services responsive?

Requires improvement



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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Summary of findings

Overall summary

We rated for long stay/rehabilitation mental health wards for working age adults as requires improvement because:

- Staffing issues had affected the services ability to admit patients to the ward. There was low morale among the staff due to the staffing issues.
- There were issues with the safety of the environment inside and outside of the hospital. The staff's knowledge of ligature points was very poor. The environment made night-time observations disruptive.
- Risk assessments did not translate into risk management plans. Despite regular reporting of incidents there were recurring themes that were not being managed or escalated accordingly.
- Care plans were not individualised. The paper notes were disorganised and hard to navigate making it difficult to find important information.
- Staff were not provided with regular supervision or specialist training to improve skills for working with patients requiring rehabilitation.
- There were limited ward based activities and input from occupational therapy. There was no psychologist employed at the service.
- Discharge was not effectively planned.
- There were blanket restrictions in place throughout the unit. These included restrictions on access to food.

- There was no record kept of complaints that were made to the service.
- There was poor management oversight of complaints and supervision and recurring incidents were not managed effectively.

However:

- Staff were up to date with their mandatory training. There was good practice around the management of medicines.
- There was appropriate use of bank staff.
- The ward complied with guidance on same sex accommodation.
- Staff adhered to the principles and requirements of the Mental Health Act and the Mental Capacity Act. Staff used recognised assessment tools and outcome measures.
- There were effective shift to shift handovers.
- Patients were encouraged to be independent as part of their recovery and discharge.
- We re-inspected the service in January 2017 and found that staff had addressed a number of risks identified with the environment as a result of the issuing of an urgent requirement notice.

Summary of findings

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

Are services safe?

We rated safe as inadequate because:

- Low staffing levels due to sickness and turnover rates had caused the ward to be closed to admissions and discharges. Staff found that the low staffing levels were highly stressful and had impacted on their ability to provide patient care. Patients wishing to utilise escorted leave were often not able to.
- While staff completed risk assessments, they did not always translate these into risk management plans. Despite repeated incidents, there was little learning or proactive risk management taking place around recurring incidents on the ward.
- There were omissions in the identification and reporting of incidents that warranted a safeguarding referral. As a result, the wider population of the hospital was not safeguarded against recurring risk events.
- There were no viewing panels on the downstairs bedroom doors which meant that patients were often woken by staff doing the night time observations and entering patients' rooms.
- There was poor understanding of ligature points by the staff. Not all areas of the hospital were assessed for their ligature risk. There were a number of risks with the environment identified.
- Staff did not record the room temperature in the clinic room.
- There were a number of unwarranted blanket restrictions in place.

However:

- Staff were up to date with their mandatory training.
- There was good practice around the management of medicines and encouraging independence in patients.
- There was appropriate use of bank staff.
- The ward complied with guidance on same sex accommodation.
- We re-inspected the service in January 2017 and found that staff had addressed a number of risks identified with the environment as a result of the issuing of an urgent requirement notice.

Inadequate



Are services effective?

We rated effective as inadequate because:

- Care plans were not individualised.

Inadequate



Summary of findings

- The paper records were not arranged according to their index which made it hard to easily access important care information.
- Staff had poor awareness of national institute for health and care excellence (NICE) guidance. There was limited occupational therapy input. There was no psychologist employed.
- Staff did not receive regular supervision and went many months without being supervised. Poor performance issues were not dealt with quickly and effectively.

However:

- Staff adhered to the principles and requirements of the Mental Health Act and the Mental Capacity Act.
- Staff used recognised assessment tools and outcome measures.
- There were good links with external services and there was clear evidence of collaborative working.
- There were effective shift to shift handovers.

Are services caring?

We rated caring as good because:

- Staff were caring towards the patients and patients reported that the staff had a caring attitude and treated them with dignity and respect.
- Patients were oriented to the ward on admission and provided with relevant information.
- There were daily meetings to engage patients.
- Carers reported that they felt included in the care.

However:

- Patients were not always included in the care planning process.

Good



Are services responsive to people's needs?

We rated responsive as requires improvement because:

- The number of beds had been capped at eight when they were set up to provide care for 11 patients. The hospital was shut to admissions and transfers so was not able to respond to patients requiring a rehabilitation bed.
- There was poor discharge planning within the hospital. Discharge care plans were identical and not personalised.
- There was a limited activity timetable with no activity being provided on Fridays or weekends.
- There was no record of complaints made to the service.
- Access to food was restricted to certain times of the day.

Requires improvement



Summary of findings

However:

- There was evidence that the hospital had utilised the local acute wards for patients requiring a higher level of care.
- The average length of stay was 260 days.
- Patients were free to use their mobile phones and free to personalise their bedrooms.
- Patients were encouraged to be independent in their cooking and budgeting. They were given money each week to buy food and were required to prepare their own meals.
- The hospital was suitable for disabled patients. Information leaflets were clearly displayed for patients.

Are services well-led?

We rated well-led as inadequate because:

- There was no oversight of staff supervision; there was a failure to support staff through the implementation of the supervision policy.
- There were no systems in place to record a central log of complaints made to the service. This had impacted on the services ability to evidence how it responded to complaints and how it learned from complaints.
- Despite staff recording incidents on the electronic system, there was not a robust system of learning and managing risks associated with recurring incidents.
- There was low morale within the team; there was a high sickness and turnover rate. Staff felt they were not supported and there was a high level of stress.
- There was little support provided by the senior management within the trust.
- There was not a regular forum for staff to feedback on the running of the service.

Inadequate



Summary of findings

Information about the service

Woodlands is a 11 bedded mixed sex community rehabilitation unit. It offers longer term rehabilitation for people who needed to learn or re-learn the skills required to live independently. Patients are offered help and support with a range of self-care and life skills to equip them in their recovery.

The service accepts patients from the local area and mainland England. It is registered to accept people detained under the Mental Health Act and on our visit the majority of patients were detained. The service was previously inspected in 2014 and was rated as requires improvement.

Our inspection team

Head of Hospital Inspection: Joyce Frederick

Lead Inspector – David Harvey

The team comprised two inspectors and a specialist advisor with specialist experience of working within similar environments.

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 where 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?

During the inspection visit, the inspection team:

- visited the ward and undertook a specific check of the environment

- spoke five with members of staff including nurses, support workers an occupational therapist and domestic staff.
- interviewed the ward manager
- spoke with three patients
- observed an activity
- spoke with four carers
- held a focus group with five staff members
- reviewed six sets of care records including mental health act paperwork
- had a specific check of the management of medicines.

What people who use the provider's services say

Patients generally reported a caring attitude from staff. They stated they felt supported by them and that staff treated them with dignity and respect and that they treated them well.

Summary of findings

Good practice

A sexual health nurse attended the ward monthly to give advice on sexual health and to complete well women and well men checks.

Areas for improvement

Action the provider **MUST** take to improve

Action the provider **MUST** take to improve

- The provider must ensure that relevant staff working within the service are aware of and able to identify ligature points. We found that while the provider had undertaken a ligature audit, staff were not aware of ligature points within the hospital.
- The provider must ensure the safety of the environment. We found there to be numerous risks in the garden of the service that put staff and patients at risk of injury.
- The provider must ensure that patients are able to utilise escorted leave. We found that the lack of staff on the ward had meant patients went without escorted leave and were often limited to a short window while handover was taking place.
- The provider must ensure that patients are involved in care planning. We found that the care plans were on templates and were not individualised. There was little evidence of the patient being included in the care planning progress.

- The provider must ensure that staff are supervised and that there is a record kept of supervision. We found that staff had not been supervised regularly and that they did not feel supported.
- The provider must ensure that there is a complaints process that includes a log of all complaints made in order to evidence the response to complaints.
- The provider must ensure that risks to patients are managed effectively. We found that risk assessments did not translate into a management plan. There was little evidence to suggest recurring risk issues within the service were being escalated to safeguarding.
- The provider must ensure that there is a comprehensive activity timetable for the patients on the ward. We found there to be very little meaningful activity.

Action the provider **SHOULD** take to improve

- The provider should ensure that staff are aware of the National Institute for Health and Care Excellence guidance appropriate to the service to ensure staff are aware of best practice.
- The provider should review blanket restrictions on the wards. We found a number of blanket restrictions.

Isle of Wight NHS Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---------------------------------------|---------------------------------|
| Woodlands | Woodlands |

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.

- Staff were trained in the Mental Health Act and had good knowledge of the sections and restrictions of the Mental Health Act.
- We reviewed notes for their adherence to the Mental Health Act. Section paperwork was well completed with the required assessments present. Paperwork was up to date and filled in correctly. Consent to treatment was assessed and the necessary consent forms were then kept with the medication cards. Section 17 leave forms

were struck through appropriately and there was evidence that the Ministry of Justice had approved leave for patients that required it. We found that patients' rights under section 132 were read periodically.

- Audits were conducted by the Mental Health Act administrator in order to scrutinise section papers. A recent audit had identified that a patient had been transferred to the hospital whose section may not be valid. The staff took action to reassess this patient under the mental health act and to arrange legal advice.
- Staff were aware of who to contact in the event a patient required an independent mental health advocate (IMHA). IMHA information for patients was displayed on the ward.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in the Mental Capacity Act. We found that they adhered to the principles of the Act and assessed capacity at appropriate times. Care records showed good use of the Mental Capacity Act and in appropriate situations.

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

- Woodlands was set over two floors with bedrooms on both floors of the building. The nursing office was situated downstairs with good visibility into the garden patio and smoking area. There were poor lines of sight downstairs due to the layout. However, due to the lower risk of the patients and the long term nature of the service the risk was mitigated through the referral and acceptance criteria. This criteria stated that a patient would need to be safely managed in the environment. The upstairs of the building was not occupied by ward staff. While there were bedrooms upstairs with viewing panels these were unoccupied. Downstairs bedrooms did not have viewing panels for staff to easily observe patients without disturbing them.
- The service undertook a ligature assessment throughout the inside and outside of the building. Ligature points were rated according to their risks. This assessment then put controls in place to mitigate the risk posed by ligature points. However there had been no ligature assessment of the gym area and the numerous risks that the gym equipment and environment posed. There was no assessment of certain ligature risks in the garden. There were ligature scissors in the nursing office for staff to use in the event of a ligature incident. The one ligature incident over the previous year did not involve use of a ligature point. However, despite the assessments taking place and control measures we found that staff were not aware of the numerous dangers posed by ligature points within the building. The lack of awareness around what constituted a ligature point and where they were within the building meant that staff were not aware of the potential risks to patients within the building. This meant that they were not able to mitigate these risks effectively.
- Woodlands complied with same sex accommodation guidelines. There was clear separation of male and female sleeping areas. There were both male and female allocated bathrooms. However, due to the age of the building and limited space there was not a separate female lounge.
- Emergency medication and a defibrillator were in place for staff to use in the event of a medical emergency. These were checked twice daily to ensure that they were fit for use. The clinic room was equipped with equipment such as scales, an electrocardiogram machine and blood pressure monitor to monitor physical health. The stickers showing the last portable appliance testing (PAT) date showed that some of the equipment testing was overdue.
- The clinic room was visibly clean and well maintained. However the clinic backed onto the garden where the inside of the room was clearly visible from houses around the building and from the garden itself. One of the windows was covered by a curtain. However, the other was not so there was a risk of breaching privacy and confidentiality. The room temperatures within the clinic room were not recorded regularly. Staff checked fridge temperatures daily to ensure that temperature sensitive medication was stored at the correct temperature.
- The ward areas were visibly clean throughout the inspection. Staff and patients noted that the ward was cleaned regularly. However, there were times that a cleaner was not present on the ward for a number of days. This meant that the ward became increasingly dirty and that vital areas such as bathrooms and toilets were left without being cleaned. We found that where there had not been a cleaner, this was reported as an incident. A cleaner was then nominated to attend from elsewhere within the trust.
- The ward was well maintained inside and in a good state of repair. We found however that there were issues with safety in the garden of the hospital. There were numerous risk items and broken furniture piled in the garden and an old mattress and sofa left out the front. We found that the shed containing various risk items was unlocked; the greenhouse had a broken panel of glass with shards of glass inside; weed and slug killers were left out in the garden. We found that the smoking

Are services safe?

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shelter that was made out of a wooden shed was unstable. While there had been no reported incidents related to the above the lack of attention to the risks of the garden meant that an accident could occur injuring either a patient or staff member. This has been subject to an urgent requirement notice.

- We re-inspected the service in January 2017 to check on the progress made on the environmental issues raised about the garden of the service. All environmental concerns had been addressed and there had been an inventory of the contents of the shed made in order for staff to sign items in and out.
- Staff did not regularly check the environment for risks. We found that while infection control and ligature audits were conducted there was no routine walk round to check issues such as maintenance of the building and environmental issues.
- We found staff adhered to infection control principles. There were posters displayed around the wards reminding staff and patients of principles such as cleanliness and handwashing. An infection control audit conducted by an external auditor took place yearly; a self-assessment for infection control took place every three months. This ensured that any problems related to infection control were identified.
- Staff had access to a pinpoint alarm system. This system meant that they were easily able to call for assistance in the event of an emergency.

Safe staffing

- There were a total of 14 substantive staff. Recent staffing issues within the service had meant that there were no admissions or transfers into the ward. There had also been a reduction in the bed numbers down from 11 to eight. At the time of the inspection there were two members of staff on long term sick, one vacancy for a registered nurse and two vacancies for support workers that had been recruited into but were yet to start at the hospital. Despite recruitment campaigns taking place there had been great difficulty in recruiting nurses into the vacant posts.
- Woodlands had set a minimum staffing level as one registered nurse and one support worker on each shift. The shifts were split in to early, late and nights. The ward also had the option of having an extra member of staff

on during the day (nine-five) when they were fully established. We found that there was not always a member of staff on the day time (nine – five) shift but that the ward stuck to its requirements for its minimum staffing on the other shifts.

- The overall staff turnover for the previous 12 months was 14%. The average sickness rate in the previous 12 months was 12%.
- To mitigate the risks posed by the lack of staffing the manager was able to bring in bank nurses and provide over time to the regular nurses and support workers. Due to the specialist nature of the ward the manager had arranged for staff from the acute ward that worked within the trust to come over on a short term basis. This was to ensure that staff were familiar with the trusts procedures. Over the preceding three months a total of 130 shifts had been covered with bank staff.
- Staff reported that the staffing levels had caused a lot of stress. They felt that the minimum staffing numbers were not enough for the demands of the ward and that they were unable to facilitate leave due to a lack of staff and felt this was restrictive to the patients. Often staff were only able to facilitate leave at handover time when there were more staff within the building. There were not always enough staff around to provide patients with one to one time. Having only a limited window such as handover time to take a patient on escorted leave limited a patient's ability to engage in meaningful rehabilitation activities that other patients were accessing in the community. The operational policy for the service stated the need for two staff members to be in the unit at all times. Therefore the minimum staffing level would not allow patients on escorted leave the opportunity to take advantage of their leave.
- Medical cover was provided by the on-call doctor. In the event of a medical emergency staff were required to contact the emergency services.
- Mandatory training was provided to staff via e-learning and face to face training. Compliance with mandatory training was generally very good with an overall completion rate of 80%. However, safeguarding children level two and fire safety part two were both below 75% completion rate.

Assessing and managing risk to patients and staff

Are services safe?

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

- We reviewed six sets of care records including the risk assessments completed. Risk assessments were completed on admission to the service and then updated weekly by the nursing staff. Staff used the risk assessment tool in the electronic care notes. We found good completion of risk assessments but there were not always risk management plans completed from the assessment. We found that while the risks were stated there had been repeated risk events without actions to resolve the matter, for example when a patient repeatedly absconded. The risk assessments reviewed were not dynamic in that they had not mitigated individual risks from the environment of the hospital. We were told that staff did not carry out that type of assessment.
- Staff had implemented a number of blanket restrictions around the ward. We found there to be visiting times throughout the week and weekend. However, staff stated that they were not enforced rigidly so visitors were allowed at other times. There were limits to when patients could access food and they stated that outside of these times staff often denied patients food. As a result, a patient that missed lunch could go a number of hours without a proper meal. There was a policy of no music channels after 6pm.
- The front door of the ward was left unlocked so that informal patients were able to leave at will. The ward was not openly accessible from the outside so patients and visitors were required to ring the doorbell. This ensured that staff knew who was entering the building.
- Staff observed patients periodically throughout the day and night with a minimum day time observation of hourly and four hourly at night dependant on risk. We found that due to the lack of viewing panels on the bedroom doors staff were required to open the bedroom doors at night to observe the patients. This meant that patients were regularly woken up when staff were doing observations.
- Staff were trained in breakaway techniques as part of their mandatory training. This meant that if they were attacked they were able to get away from a patient. The service did not use physical restraint.
- Staff were trained in safeguarding adults and children. We found that there was a safeguarding lead within the trust and that staff were aware of who this was and how to make an alert. The procedure for making a safeguarding alert and the number for the local authority was displayed on the office notice board.
- Medicines were stored appropriately and when reviewing the clinic room found that the management of medicines was robust and that stock was in date and well kept. Missed doses were reported and a pharmacist was available to intermittently check the prescription cards. Patients on Clozapine, which is an anti – psychotic medication, were monitored to ensure there was the correct amount of medication available for them. We found that all of the patients were on a stage of self-medication in order to increase their independence around their medication regime. Staff were assessed for their competency to administer medicines.
- Children were welcome to visit patients on the ward and were required to be supervised at all times to ensure their safety.

Track record on safety

- Woodlands had not recorded any serious incidents over the previous 12 months.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report an incident and did so using the electronic incident reporting system. We found that there was regular reporting of incidents using the electronic staff record. Staff were knowledgeable around what should be reported as an incident. Feedback from incidents was given to staff from the manager following an incident.
- There were 37 separate incidents of substance misuse over the previous year and 25 recorded incidents of smoking in the building. When this occurred they reported it as an incident, however, there was little learning due to it being an ongoing issue. Action taken to reduce the risk of smoking in the building had not worked and there been no further learning and risk management put in place for staff to address the issue.

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 six sets of care records including paper and electronic versions. Staff undertook an assessment of needs on admission to the ward in order to identify rehabilitation and recovery needs and formulate a plan of care. Initial assessments were completed prior to accepting the patient so that the staff were aware of risks. Staff used recognised tools such as the Camberwell Assessment of Need and PHQ-9 which is a depression rating and diagnostic tool.
- Staff monitored physical health regularly. We found that physical health information was kept together and the staff used Modified Early Warning Score charts to record physical health. Staff used the rethink physical health tool endorsed by the Royal College of Psychiatrists to assess patient's physical health.
- Care plans were hand written using a standard tool where staff added the patient's name to the pre-written plan of care. We found that there was duplication of care plans from patient to patient with most of the patients having the same care plans. The care plans completed were not holistic or individual to patient need. There was very little personalisation on any of the care plans with the patient's views box often left blank. Patients reported that they were given a copy of their care plan to sign and were not involved in writing the care plan. There was no named nurse system in place to oversee the writing of the care plans. The purpose of Woodlands stated that staff would work with patients to develop a treatment plan which they were fully involved with. The lack of personalisation of care plans meant that patient's individual needs were not being addressed. Care plans were however up to date and reviewed regularly.
- The risk assessments and daily progress notes were kept on the electronic records system but the assessments, care plans and section papers were kept within the paper notes. When reviewing paper notes we found that while they were indexed into separate areas there was information missing from these areas. We found notes where care plans and section papers were

mixed in the front of the notes rather than separated out according to the index. This made it hard to navigate around the paper notes as the information was not guaranteed to be in the correct place.

Best practice in treatment and care

- We reviewed all the prescription charts and noted that medicines were prescribed according to National Institute for Health and Care Excellence (NICE) guidance. However, staff were not aware of the NICE guidance and we found that there were limited talking therapies available to patients on the ward as there was no psychologist employed. Therefore patients requiring a vital psychology service had to be referred to a community service where they joined an extensive waiting list. There was limited input from occupational therapy that would have helped patients regain the confidence to live outside of hospital. Staff had previously been provided with support from a psychologist through clinical supervision but this had been stopped.
- Staff registered patients at the local GP service in order for them to receive help for their physical health needs. A sexual health nurse attended the ward monthly to give advice on sexual health and to complete well women and well men checks.
- Staff completed Waterlow assessments for patients at risk of pressure ulcers. We found evidence of good monitoring of food and fluid intake for patients with an eating disorder.
- Staff used the Health of the Nation Outcome Scales to record the outcomes of treatment. There was use of Liverpool University Neuroleptic Side Effect Rating Scales (LUNTERS) to assess the extent of side effects related to antipsychotic medication. The outcome of this test would then guide staff on how side effects might be treated.
- The modern matron conducted a quarterly care record documentation audit. The audit rated Woodlands as 78% compliant on the standards set within the audit however did not show which areas of the audit they were compliant and non-compliant. The action plan was not specific to Woodlands and the audit had not identified the numerous issues with a lack of personalisation in the care planning and the lack of management plans in the risk assessments. Therefore

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.

there was no specific improvement on the audit for Woodlands to learn from. We found that there was auditing against compliance with the Mental Health Act and with infection control standards.

Skilled staff to deliver care

- There was a limited range of health disciplines providing input to the ward. Occupational therapy (OT) was provided 3.5 days per week by a qualified OT and OT technician, there was no allocated psychologist and the consultant to the service provided two sessions per week.
- Staff on the ward were not experienced and qualified for the role of working in rehabilitation. There were both trained and untrained staff providing support to the patients with the qualified nurse leading the shift. Staff said that they received training that helped them with their role but did not have access to a range of specialist training associated with rehabilitation and recovery wards.
- Staff received a trust induction on starting. This induction covered mandatory training requirements. There was a separate ward based induction for staff to engage with and a folder of information specifically related to the routine and care provided by Woodlands along with relevant policies and procedures.
- Staff did not receive regular supervision. We heard from support workers and trained nurses who stated that supervision did not occur. Staff said they had gone up to two years without having any supervision. Staff therefore were unsure whether they were doing things right and we heard that they would only get told when they did things wrong. The operational policy provided to the inspection team stated that staff should receive both management and clinical supervision monthly and that written records should be kept. We requested to see records but were told that no record of supervision was kept. We found that all staff had received an appraisal for the year.
- There had been a performance issue with a member of staff on the ward. This had not been dealt with swiftly.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings took place weekly. These meetings were attended by the nursing and medical team; the care coordinator for each patient was

invited along to each meeting but was not always able to attend. We found evidence in the notes of good collaborative working between nursing and medical teams and with the re-enablement team who worked with discharge planning.

- We reviewed a nursing handover from the early shift to the late shift. The handover covered areas of care and risk while summarising the mental state and behaviour of the patients over the previous 24 hours as well as the plans for the next shift; for example if a patient was going on leave. The handover was documented so there was a record for staff to catch up on the progress of patients if they had not worked for a while.
- We found that sharing information between teams such as the GP and the re-enablement service to be effective. There was good knowledge of the roles of external services such as social services and advocacy and who to contact if needed.

Adherence to the MHA and the MHA Code of Practice

- Staff were trained in the Mental Health Act and had good knowledge of the sections and restrictions of the Mental Health Act.
- We reviewed all notes for their adherence to the Mental Health Act. Section paperwork was well completed with the required assessments present. Paperwork was up to date and filled in correctly. Consent to treatment was assessed and the necessary consent forms were then kept with the medication cards. Section 17 leave forms were struck through appropriately and there was evidence that the ministry of justice had approved leave for patients that required it. We found that patients' rights under section 132 were read periodically.
- Audits were conducted by the Mental Health Act administrator in order to scrutinise section papers. A recent audit had identified that a patient had been transferred to the hospital whose section may not be valid. The staff took action to reassess this patient under the Mental Health Act and to arrange legal advice.
- Staff were aware of who to contact in the event a patient required an independent mental health advocate (IMHA). IMHA information for patients was displayed on the ward.

Good practice in applying the MCA

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.

- The trust had a Mental Capacity Act (MCA) policy for staff to refer to. Training was provided by the trust and staff were aware of the principles of the MCA.
- Staffed assessed capacity at regular intervals with assessments apparent on ward review documentation when changes were made to patients care such as a change in medication or dosage.
- We reviewed six sets of records for adherence to Mental Capacity Act and found that all six showed that capacity had been assessed around decisions for treatment as well as capacity to consent.

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 staff interact with patients. Staff were caring towards patients and spoke to them with respectfully. The staff had built a rapport with the patients under their care; however, there appeared to be a lack of enforced boundaries with patients walking in the staff office unannounced where there was potentially confidential information and conversations.
- Patients generally reported a caring attitude from staff. They stated they felt supported by them and that staff treated them with dignity and respect and that they treated them well. However, we heard that there was sometimes a lack of consistency from staff around eating times with some staff enforcing restrictions and others not.
- Staff understood individual patient needs despite the care plans not being individualised. There was clear communication of needs during the shifts we observed and in the handover. We found there to be consideration of individual patient's interest and needs for the day with staff planning leave and activity, however individual section 17 leave was often restricted to handover time for patients needing escorted leave.

The involvement of people in the care they receive

- Patients were given information about the ward on admission. The patient information pack set out the purpose for admission to Woodlands, the admission agreement and procedures around fire alarms, smoking rules and around patients' rights.
- There were mixed reports from patients about involvement in care planning. Patients reported that they were given a care plan to sign rather than being involved in its creation. On reviewing care plans we found that often patient's views were not sought but that the care plans were signed by them. The care plans were not recovery focussed around maintaining and building on independence. Staff reported that they were proactive in including patients in care decisions. Patients filled out a summary of their progress prior to ward review with the consultant psychiatrist; this allowed reflection for the patient and allowed them to talk about what they wanted to.
- Advocacy was supplied by an external agency. We heard from patients that they had regular contact with the visiting advocate.
- Parents and carers reported that they felt included in care and were invited to meetings with the nursing staff and doctor when appropriate.
- Staff and patients convened for a morning meeting each day. Patients and staff talked about the plan for the day with activities and leave and for any issues around the ward. This meeting was not recorded.

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

- Woodlands accepted patients from outside of the Isle of Wight as well as more locally. The purpose of Woodlands was to assess and then implement interventions that were tailored to meet the mental health, physical and social needs of each individual. At the time of the inspection the hospital was shut to admissions and transfers into the unit due to low staffing levels. The ward was set up to provide care for 11 patients but the number of patients had been capped at eight due to staffing levels. Three of the 11 beds were ring fenced in order to repatriate people from the mainland back to the Isle of Wight to ensure prompt transfer of patients. As a result of the issues with staffing the unit they were not able to accept patients in need of a rehabilitation bed or provide the number of beds they were set up to provide.
- Information provided following inspection showed Woodlands had an average length of stay for the 2016/2017 financial year of 411 days with six patients discharged in the year. There was an overall average length of stay of 260 days. The patients on the ward in the same period had been there for between 80 and 1362 days. The length of stay in a rehabilitation unit such as Woodlands is expected to be one to two years. Staff told us that discharges were planned for in advance. We found two discharge plans out of the six sets of notes, these two were not personalised to the patient and were identical. Despite this staff stated that discharge would happen at an appropriate time.
- The hospital did not admit patients to rooms of other patients on leave. This meant that at any point while a patient was on leave they were able to return to the ward and to their room as they left it.
- Staff could access beds for patients requiring a psychiatric intensive care bed. When this happened it was for a short period of stabilisation before the patients were transferred back to Woodlands.
- There was one delayed discharge at the time of the inspection that was due to the lack of a community placement.

The facilities promote recovery, comfort, dignity and confidentiality

- The facilities included a lounge, clinic room, conservatory, gym, dining area and kitchen. The dining area doubled up as the activity and group room.
- There were a limited amount of spaces for individual one to one sessions and staff felt they were limited about where they could provide individual time outside of a patient's own bedroom. Family visits took place in patient bedrooms and communal areas.
- Staff allowed patients to use their mobile phones but asked them to use them only in their bedrooms. There was a ward phone for patients to use but this was located in the communal lounge rather than in an area where a telephone call could be made in private.
- Staff gave patients a budget each week to do their own food shopping. Patients were required to prepare their own lunch and dinner. There was a separate ward budget to buy essential items such as bread and milk and cereal for breakfast. The ward also provided essential items for lunch and dinner so that patients always had a variety of ingredients to create a meal. There were signs up in the kitchen telling patients what times they could and could not access food. This included cut off times for breakfast, lunch and dinner. However staff said that they would not stop someone from eating and that patients were allowed to access drinks and snacks at any time of the day. One patient reported that staff were inconsistent in enforcing this rule.
- Patients told us they were free to personalise their rooms as they wished.
- All patients had a key to their own bedrooms. This ensured that they had somewhere safe to lock their possessions.
- There was an activities timetable facilitated by the occupational therapy staff for three and half days of the week. The occupational therapy team were shared with other psychiatric units within the trust so there was no full time provision for Woodlands. This meant that outside of the timetable there was little ward based activity. We found when reviewing the activity timetable that of the seven activities provided, ward round and an occupational therapy assessment clinic and one to one

Are services responsive to people's needs?

Requires improvement 

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time were considered as an activity. There were no ward based activities on a Friday or at the weekends so there were only five activities within the week that were based on rehabilitation skills. Staff stated that they would encourage activities within the community where appropriate.

Meeting the needs of all people who use the service

- The service was able to accommodate patients with disabilities and there was an adapted bedroom and bathroom.
- There were information leaflets available for patients. These included information on how to make a complaint, advocacy and local community groups. Staff were able to arrange an interpreter as well as leaflets in different languages around the mental health act and patient's rights.
- There was no onsite spiritual support; patients were encouraged to access this in the community.

Listening to and learning from concerns and complaints

- Information on how to complain was provided to patients on admission. Details were in the admission pack. There were information leaflets for patients to take that explained the complaints process. There were forms in place for patients to fill in so that the manager could respond.
- Patients reported that they were aware of how to complain.
- We requested complaints information from the manager of the service. However, this was not readily available. As there was no record of verbal and written complaints being kept, there was no evidence to show how the service responded to complaints, any learning to show how it had improved and how it fulfilled its duty of candour as a result.

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 reported that they were aware of the trust's values and these were displayed in the ward office. The staff were aware of who the senior managers and executives were within the trust but said that they had not visited the ward for some time.

Good governance

- There were processes in place to ensure that the nursing team received the mandatory training to allow them to work safely within the hospital. Overall, mandatory training compliance was above the minimum requirement set by the trust.
- Staff received an annual appraisal from the manager of the service. However, staff were not receiving regular supervision and there was no oversight by management. The lack of oversight meant that there was no process to ensure that staff were supervised and supported regularly. Staff felt that they were not supported and that they had to learn the job themselves.
- Due to staff sickness and vacancies, a decision had been made by the trust to close the ward to admissions and transfers. There was appropriate use of bank and agency staff to cover the gaps caused by sickness and vacancies while the trust worked on a medium and long-term solution to the staffing issues.
- There was no oversight or record of complaints made by patients within the service. The failure to record these complaints meant that the service was unable to evidence its response and its duty of candour. While incidents were reported on the care records system we found that learning was not regularly cascaded through the team or in team meetings. Staff felt that there was little learning from incidents and positive steps made to reduce risks of recurring incidents. There were repeated incidents of substance use and smoking on the ward that had little effective management of the problems.

- Staff were able to submit items to the trust risk register. The staffing issues had been added in order to alert the senior team.
- The manager attended once weekly quality meetings with senior management looking at the quality of the work being completed by the ward. For example the completion of risk assessments. This ensured the ward was communicating with the wider trust.

Leadership, morale and staff engagement

- Staff were not sure whether the senior team knew what their function was as a rehabilitation unit and it was unclear from staff what the model of care was for the patients in the service. We heard that there was little support from senior management within the trust and that they only became involved when there were issues. There had been an incident requiring investigation around staff performance that had been poorly handled by the trust.
- The sickness rate for the service was high which had impacted on the staff team. Staff had been on a stressed out at work course due to the levels of stress they were experiencing working at Woodlands.
- We spoke with staff within a focus group but they were not confident in speaking about their concerns together with each other. Staff reported that morale was low but despite this they tried their best for the patients and to support each other in doing so.
- Staff were not engaged in regular team meetings. There were two meetings in 2016 prior to the inspection date. Risks were discussed in these meetings and there was clear opportunity for staff to give feedback on the services development however with little regularity of the meetings staff were not given a regular forum to feedback.

Commitment to quality improvement and innovation

- There was no formal commitment or participation in quality improvement schemes or innovation.

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 |
|--|--|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury | <p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12(2)(a)(b)(d) HSCA (Regulated Activities) Regulations 2014.</p> <p>Safe care and treatment</p> <p>Whilst there had been an assessment of ligature points and controls put in place to mitigate the risk, there was very poor knowledge amongst staff about what constituted a ligature point and what the environmental risks were.</p> <p>Staff were not translating risk assessments into management plans. Therefore recurring risks were not being dealt with effectively. Recurring risks were not escalated effectively.</p> <p>Staff were not being regularly supervised. There were staff going for long periods of time without regular supervision. Staff did not feel supported.</p> |

| Regulated activity | Regulation |
|--|--|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury | <p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Regulation 18 (1) HSCA (Regulated Activities) Regulations 2014.</p> <p>Staffing</p> <p>There were not always enough staff on duty for patients to get escorted leave. We heard that staff had to limit escorted leave until handover time due to having extra staff within the building. Often the ward was not able to cover the 9-5 shift that would allow more freedom in providing escorted leave.</p> |

This section is primarily information for the provider

Requirement notices

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

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

Regulation 9(3)(b) HSCA (Regulated Activities) Regulations 2014.

Person-centred care

There was poor patient involvement in care planning. Care plans were on a template and there were not always patient views sought.

The provider must ensure that there is a comprehensive activity timetable for the patients on the ward.

Regulated activity

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Regulation 16 (2) HSCA (Regulated Activities) Regulations 2014.

Receiving and acting on complaints

The manager kept no log of complaints so was not able to evidence any complaints received or the response to complaints.

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.