Details of visit	**Shackleton Ward – Inpatient mental health ward visits**
Service address:	**St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG**
Service Provider:	**Isle of Wight NHS Trust**
Date:	**24th January 2019**
Authorised Representatives:	**Joanna Smith and Maurice Dix**

Acknowledgements

Healthwatch Isle of Wight would like to thank the service provider, people who are using the service, visitors and staff for their contribution to the Enter and View programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users and staff. It is only an account of what was observed and contributed at the time.

What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit.
In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the CQC where they are protected by legislation if they raise a concern.

Purpose of the visit

This visit was arranged as part of an ongoing mental health work plan. The visit was designed to look at the experiences of people who spend time as inpatients on all local mental health wards either voluntarily or under sections of the Mental Health Act (1983).

Methodology

The visits took place unannounced. The Director for Mental Health Services at the Isle of Wight NHS Trust along with senior members of staff were made aware that Healthwatch Isle of Wight would undertake visits related to the mental health work plan and were given a 2 week window but were not informed exactly when, or what the visits would involve.

The focus areas of the visit were as follows:

- **Environment**
- **Activities**
- **Staff interaction**
- **General observations**
- **CQC Concerns;**

The most recent CQC (Care Quality Commission) report highlighted the following:

- There is no sign to state that one lounge is a female only lounge.
- Patients` bedroom doors were locked during the day.
- Patients were unable to access food or drink independently.
- The environment is clinical not homely.

In response to this information, the Enter and View representatives checked to see whether improvements had been made in line with the CQC findings.

Results of Visit

Description of ward taken from the IOW NHS Trust website:

''**Shackleton Ward** is an 8 bedded unit which provides specialist inpatient assessment and care for those suffering with dementia. The unit is able to offer assessment and advice to relatives/carers and residential homes on the management of people who present challenging problems in the care that they require. The unit is also able to offer advice to/for individuals who are not receiving inpatient care.''

Environment

Shackleton Ward is situated on the first floor of the hospital, with very limited access to the garden area. To access the garden people must either go down in the lift or use the stairs. There is then a short walk along the main corridor of the hospital prior to reaching the garden. This can be problematic if the person with dementia is agitated or anxious.

The first lounge on the ward contained a television which was secured to the wall in a wooden cabinet and six plastic covered chairs. No other furniture or fittings were evident in the room and the walls were bare.
An occupied bedroom that was viewed was stark, unwelcoming and spartan with bare walls. It was not personalised and no personal possessions were evident in the room. The only furniture observed was a hospital bed and a wardrobe secured to the wall.
Curtains were observed at bedroom windows. There were no light switches in the room and we found them located outside in the hallway, making it difficult for patients to control the lighting in their bedroom.

Best practice in care for people with dementia emphasises individualised approaches and the importance of the presence of familiar objects and possessions.

Another occupied bedroom just contained a hospital bed. We were informed that the wardrobe had been removed. Only one bedroom we saw, contained any personal possessions (photographs of family members stuck to the window frame).

There were no quiet areas available for patients to sit with their family members and people`s voices could be overheard in different areas of the ward. Staff informed us that if the patient had a visitor, they would take a chair into their bedroom for them if necessary.
We were informed that only one bedroom had en-suite facilities.
The second lounge was also sparsely furnished and a television was on in the background. Further along the ward, a third lounge was situated and contained a dining table and chairs. A very low level plastic chair was seen just inside the doorway. When asked how patients would be able to get out of this, staff informed us that this was a “relaxing chair” and was not often in use.

No light switches were noted in the lounges and again, these were found outside in the hallway. Shackleton ward currently shares a small kitchen with an adjacent general ward, which makes it more difficult for staff to prepare snacks and hot drinks for patients.
Toilet, bathroom and bedroom doors were all locked, with patients having to ask staff if they wanted to use the bathroom or enter their bedroom during the day. (We were informed that patients can easily open the bedroom door from the inside).
There is a section of the hallway which is used as a dining area and also houses the nursing `pod`. A ward telephone is also located here and if it rings during a mealtime, then patients will be disrupted.

Activities

The ward has a low level of occupational therapy and physiotherapy support and this is not provided on a structured basis.
There was a small section of the dining room (in the staff hub) where artwork can take place.
Staff informed us that if there are sufficient staff on duty, then they occasionally take patients out into the local community for a drive to the seafront for example. “It’s the only thing we can do for them to give them a normal life”. Staff acknowledged that the poor environment and lack of therapeutic activities may contribute to anxiety and stress for patients on the ward.

Staff interaction

Three of the staff on duty during the visit were agency staff.
We were informed that Tier 1 dementia training is now mandatory for all staff across the IOW NHS Trust. Four staff within the mental health team have completed the four day Gemma Jones dementia training course as well as the two day train the trainer course and this will enable them to deliver training to staff within the hospital. Staff also complete Breakaway training and Physical Intervention training, although we were informed that this would be used as a last resort.
Staff were observed supporting people with their basic needs but there was little social interaction and no therapeutic activities completed during the duration of our visit.

General observations

We were informed that there are currently four patients on the ward although one was on home leave. (This is where the person may be granted leave as part of the transition period before they are discharged). Most patients stay on the ward for at least a month and some much longer than this.
A visitor to the ward felt that the care given to patients on the ward was very good although the environment was described as “serving a purpose”.
Finding an appropriate level of care and support for the patient following their discharge can be problematic, with staff mentioning difficulties in finding appropriate places of care for the person and delays in funding can also lead to delays in the person being discharged.

CQC concerns:

During the visit, no female only lounge sign was seen by the enter and view panel.

Patients` bedroom doors were locked as were the toilet doors, which meant patients had to ask staff if they wanted to enter their rooms or go to the toilet. (We were informed that the bedroom doors can easily be opened by people when they are inside the room).

Patients were unable to access food or drink independently and would have to ask staff if they wanted something to eat or drink.

The environment felt clinical, unwelcoming and not homely.

Recommendations:

1. The immediate environment should be enhanced to provide a more homely, welcoming feel, with input from patients and their families/carers.

2. Patients should be able to access toilet facilities at all times.

3. Individualised therapies and therepeutic activities should be provided on a daily basis

4. Light switches should be moved immediately to ensure patients can control the lighting in their bedrooms

5. Staff should implement a proactive approach to supporting people, in order to minimise the risk of patients becoming anxious and agitated.


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