MENTAL HEALTH BOARD

(GIBRALTAR)

ANNUAL INSPECTION REPORT

2020

OCEAN VIEWS MENTAL HEALTH FACILITY

COMMUNITY MENTAL HEALTH TEAM

MENTAL HEALTH BOARD

(GIBRALTAR)

Annual Report (2020)

INTRODUCTION

1. **The Mental Health Act 2016 (MHA) requires the establishing of a Mental Health Board (MHB) under Part 9, Sect.113 (1) of the Act. Such a Board was established on 23rd April 2018, under Government Notice No. 674 (Appendix A). Two additional members were appointed in May 2019 at the request of the MHB. It currently consists of eight members, two of whom are registered medical practitioners, two are barristers, one a retired SRN, and three lay members with extensive community experience.**

2. **Under Section 115 (1) of the MHA the functions of the MHB are to satisfy itself as to the state of the Ocean Views Facility (OV) at Europa Road, and the Community Mental Health facility (CMHT) at Coaling Island, their administration, and the treatment of patients. It may make inquiry into any case where it appears there may be ill-treatment, deficiency in care and treatment, or *improper detention or reception into guardianship.* As often as it may think appropriate, the MHB may visit and interview, in private, patients who are liable to be detained under the Act. Further, the MHB shall bring to the attention of the Minister any matter concerning the welfare of patients which the MHB considers ought to be brought to his attention.**

3. **In furtherance to the exercise of its functions under subsection (1), the MHB may, under subsection (2) refer cases to the Mental Health Tribunal (MHT); interview and medically examine, in private, patients held under the Act; and may require the production of and inspect any records relating to the detention or treatment of any person who is or has been subject to the Act.**

4. **Under Section 116(1) of the MHA, the MHB is required to make an annual report to the Minister at the end of each year concerning its activities. The MHB has defined its year as concurrent with Government's financial year, ending on 31st March.**

THE MENTAL HEALTH BOARD

5. **The Mental Health Board (MHB) first met formally on the 6th June 2018. During the period under review it has met monthly on eleven occasions, as prescribed by the Mental Health Act 2016 (MHA). The Government re-shuffle of ministerial responsibilities resulted in the loss of its Secretary as Justice was assigned away from the St Bernard's Hospital complex. The MHB laboured uncomfortably with the eventual assignment of an officer with onerous other duties, soon lost to the exigencies of the COVID-19 pandemic. MHB is now happy to report on the appointment of a regular, experienced officer.**

6. **MHB has established access to the Minister for matters appropriately requiring attention at that level. At a more practical level, MHB is programmed to meet with the Medical Director, once a quarter, and regularly with OV management as and when required, once the current Covid 19 emergency ends.**

7. **It is not the role of the MHB to run or manage the Mental Health Service. The MHBs role is in part to provide a platform and an independent channel which enables the community (patients, family, friends, and staff) to access, check, and question the service provided at OV and CMHT, in furtherance of their proper governance and development, in favour of a very vulnerable section of our society.**

8. ***Two years into its establishment, the Board has continued to function without a permanent location. It currently meets at the St. Bernard's Hospital, courtesy of the hospital administration, with the inherent limitations this entails. The statutory duties and work of the MHB are seriously hampered by this lack of a suitable independent location, conveniently accessible to its Members and community, enabling it to publicise its role and function, providing a public address, and able to meet individuals confidentially and privately, and keep and access sensitive and confidential records***

9. **The allocation of temporary premises at the vacated Primary Care Centre at ICC was cut short by the COVID-19 pandemic. In any case it would be available only up to September 2020. It had no means of communication other than by private telephone, and lacked any facility for safe storage. MHB has been assured that more permanent and suitable premises are already in the process of being prepared, with OV assisting where it can in the meantime.**

10. **An important step forward is the coming creation of MHB's domain that will enable the Board to project its role and function within the community; making it accessible to all interested parties and offering the opportunity for individual interchange on a confidential basis.**

11. **The MHB had been functioning with no funding of even a minimal kind, requiring it to depend on the goodwill of actors within the GHA or of its own members. This matter has now been addressed and resolved and the proper administrative protocols established via the OV administration.**

12. **Members of the MHB are *acutely aware of their need of acquiring expertise for the proper and effective exercise of their duties* under the Act and place training in all ramifications of the legislation as one of its priorities.**

13. **MHB welcomed its continued participation in the in-service training provided by U.K. Solicitors specialising in mental health, under Peter Edwards Law, on the 2nd May 2019. Members also attended the week's course at the University of Gibraltar, commencing 8th November 2019, on transgender awareness and protocols for a code of practice.**

14. **Members are regularly invited to participate in the professional ad hoc talks and deliveries at OV, through the kind offices of its member, Dr. D. Pariente.**

15. **Although the MHB participated in the Mental Health Situational Analysis organised by the Public Health Department of the GHA, through an NHS (UK) team, in March 2019, *it has as yet not received the requested copy of the outcome of this analysis, important to the MHB's review of its activity.***

16. **MHB has actively intervened in advocating for patients who lack capacity through the Court of Protection. Though successful in the one case, *the intervention has highlighted the lack of an effective co-ordinated means for a resolution of cases within a reasonable timescale.* The particular case dealt with took almost two years to resolve despite consistent pleading. *It has highlighted the need for dedicated legal support to be provided for the OV management..***

17. **The failures to implement the requirements of the Act at an adequate level are compounded by the fact that (1) A s12 Approved Doctor List has still not been published by the Minister, as required by the Act. (2) The Code of Practice remains in draft form, is based on a discarded England Mental Health Act 1983 version**

18. ***The MHB finds that the Code of Practice document, required under Section 106 of the MHA, is still undergoing an update which as yet has not been finalised, making it less effective. This is a crucial document for all individuals acting under the requirements of the MHA.***

19. **The MHB's second inspection, as required under Section 116(1) of the MHA, was completed by the Board on the 24th February 2020. Its findings, observations, and recommendations are set out below together with copies of detailed team findings as appendices. *It is emphasised that this report is not a comprehensive report on the mental health service but a snapshot taken at a particular time and place and thereby limited in its scope.***

20. **The work of the Mental Health Board, Second Opinion Appointed Doctor and the Mental Health Review Tribunal are becoming increasingly onerous and amount to a heavy commitment in time. These functions need to be adequately supported in the discharge of their statutory duties. It is not possible to continue relying on volunteers for such onerous functions.**

21. ***Arising from the above, MHB feels strongly that in-depth professional audits of the Facilities should be carried out by an external, independent body such as the UK Care Quality Commission, at intervals to be determined, that would set the road-map for development of the mental health service for the GHA , and guide the work of the MHB.***

22. **The Board is grateful for the welcome, support, and assistance its members received throughout their inspection from all staff at OV and CMHT.**

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MENTAL HEALTH BOARD INSPECTION (2020)

GENERAL BACKGROUND:

23. ***Ocean Views*** **holds a total of 52 patients when full. At the time of the inspection Staffing levels were as follows: 8 (*8.5*) Registered Mental Nurses (RMNs) two of which are Charge Nurses; 6.5 (*5*) Enrolled Nurses (ENs); and 7 (*3.5*) Nursing Assistants (NAs) at *Dawn Ward (Rehabilitation)*, catering for 13 (*20*) patients (7 at Rockside flats) – 15.5 (*13*) RMNs two of which are Charge Nurses; 10 (*7*) ENs, and 9 (*4*) NAs at *Horizon/Sky Ward (Acute/Intensive)*, catering for 18 patients; 8 (*7*) RMNs one of whom is a Charge Nurse; 1 Staff Nurse (0); 4 (*4*) ENs; 9 (*5.5*) NAs; at *Sunshine Ward (Elderly M.I.)*, catering for 14 patients. The ARC or activity area, is staffed by 3 Occupational Therapists (OTs), 1 OT Assistant, 1 EN, and 2 NA. It was noted 2 RMNs provide A & E liaison. *( ) = 2019 levels**
24. **3 ENs have been backfilled by NAs to be replaced in September when they qualify; 4 ENs are undergoing RMN training; 1 NA is completing EN training.**
25. **There are 5 Consultants Psychiatrists posts: 4 Full time and 2 part-time, one working with children, and the other with Dementia patients. Pharmacy cover is provided 4 hours per week. Administrative assistance is provided by a Manager and two clerical officers.**
26. ***Community Mental Health Team (CMHT)*** **– (Coaling Island) has 80 patients on active medication and 500 on its community care list. CMHT is staffed by 4+1 RMNs, one acting as Team Manager; 3 CPMs; 6 ENs; 1 NA.**

OBSERVATIONS AND RECOMMENDATIONS:

Review of Representations arising from the Mental Health Report 2019

27.a) The appointment of two additional Members to MHB;

b) The re-drafting/updating of the Code of Practice contracted to Legal Chambers and in process of completion;

c) The appointment of two extra clerical officers to OV and one to CMHT administrations;

d) The centralisation of records under the General Manager and a weekly audit by Matron or Charge Nurse; and the introduction of computer software (Big Hand system) clearing backlog of medical notes and letters;

e) Identification of three Charge Nurses to structure inter-ward/management and communication and to ensure cover during absence of key managers;

f) Programming of on-site pharmaceutical cover for 4-hours per week;

g) Walk-in, first call liaison facility at OV – all day/all week - to reduce attendance at A & E clinic at St Bernard's Hospital constitutes a major improvement

h) Appointment of Mental Health Liaison Nurses and identified area at A & E to reduce waiting times;

i) On-call 24/7 availability of doctor cover, with programmed 2-sessions weekly;

j) Contract staff appointments established on basis of two-year periods minimum, providing more continuity

k) In-service provision on MHA 2016 through UK Legal Firm for senior mental health staff;

l) Structured in-service training programme is to be introduced mid-year;

m) Resolution of the Court of Protection case;

n) The Rock Flats and Kent House/Sandpits flats now being fully utilized.

Direction and communication

28 Government's increasing investment in mental health at many levels may be evidenced through the OV and MHRT facilities. The growth in community interest in matters of mental health is equally apparent. But MHB is conscious that while relevant activities and services are being developed under the GHA umbrella, *there is a continuing increasing and vital need to establish an overall cohesive strategy for mental health*, encompassing all of these growing elements. MHB made this crucial point in its report last year and it continues to emphasise its importance.

The Department of Education's Mental Health Project for Schools continues to provide an excellent working model of how a coherent, service-wide strategy may be pursued. It raises the question, however, of how such programmes may continue and develop beyond schools and into the community.

29 *There is a need for closer coordination and regular communication*, especially where roles and responsibilities are not always clear, and especially when units are not physically near each other. This is especially important when patient care and supervision also involves other agencies such as the Care Agency, Social Services, and RGP. The re-structuring of the Ministry to Health and Care offers a good opportunity.

30 Within OV and the CMHT, regular access to management and senior professional elements need to be constantly reviewed and structured. *Opportunities for regular feedback should be structured into daily routines and used as opportunities for development and training,* especially for junior and recently appointed staff.

Administrative and Clerical Support

31. The addition of three clerical officers, following MHB representations in their Report last year, has provided an obvious improvement in servicing the needs of OV

and CMHT. Inter alia, they provide support to the newly appointed Matron who in turn is shaping OV's nursing support structure.

32 MHB had pointed to the need for effective cover during the absence of key managers, suggesting an assistant matron. The proposal was assessed and resulted in identifying three Charge Nurses, to cover each Ward in time of absences, in lieu of an assistant matron.

33 Following representations from MHB and others, the creation of a walk-in, first call facility at OV, replacing the need to first attend at A & E at St Bernard's Hospital, has been a very positive and welcome step forward.

34 An s12 Approved List must be prepared and published in the Gazette. The Minister can delegate this function to the Mental Health Board and add to its function that of s12 Approval Panel.(vide appendix B)

35 Though eased to some extent by the employment of the extra clerical staff; it is clear that Consultants carry a larger administrative load that their counterparts in UK, as they lack any junior professional support to deal with the more routine matters. *GHA should give serious consideration to the appointing of junior assistants, which aside from supporting their more senior colleagues would serve as a route for the identifying future prospects.*

Pharmaceutical Cover

36 Following MHB's representations in last year's report, OV gets pharmaceutical cover four hours per week. Though this improvement is welcomed, *MHB is still of the view that more substantial cover remains necessary to provide the regular detailed service needed.* Medication and its correct application is possibly one of the most basic provisions in a mental health facility.

37 As MHB reiterated in last year's Report, the Bella Vista, Ocean Views, and Hillside facilities would seem to provide the 'critical mass' warranting the *availability of a permanent pharmacist presence.*

Development and Training

38 Staff interviewed were highly committed to the Service and its patients, often acting beyond the scope of their role. The provision of additional nursing staff and a more structured deployment between the wards, especially the identifying of Charge Nurses, has brought about a slightly less harried atmosphere to the wards. The same, however, could not be said of the ARC and Rehabiltation Centre (vide appendices C and E)

39 New entrants into this service receive the most basic training, with their continued professional development taking place in situ through the hustle and bustle of daily routine. *Knowledge of the MHA (2016) and its statutory requirements appears thin despite the fact that all staff bear clear legal personal responsibility under the Act, each at his/her own level.*

40 There are two basic, fundamental documents that should be provided to all employees of OV and CMHT as well as being accessible on each Ward and office. These are: MENTAL HEALTH ACT 2016 and the CODE OF PRACTICE, Mental Health Act 2016.

41 **The need for a structured in-service training programme has been recognised and MHB advised it would be delivered, commencing late March through to April. It is important this initiative not be lost due to the pandemic disturbance throughout the Service. It will provide a necessary and important pause where new practices, policies, and structures may be promoted and absorbed. U.K. expertise should be accessed regularly for this purpose, especially in auditing and encouraging good practice.**

42 **It is re-emphasised that the essential and basic need for stability, routine, and regularity in the *treatment of OV patients is not enhanced through short-term contract appointment of staff*, especially when terms may not be clear nor any options for extending explained.**

43 **Given the peculiar bi-lingual culture of the community, with the particular problems this might create in the treatment of mental health patients, *every effort should be made to promote and encourage psychiatry locally as a career***

Admission and Treatment of Patients

44 ***Specific attention is drawn to the findings detailed in Appendices B and D***

45 **There is no routine admission physical medical examinations, which is a cause for concern. Psychiatric Consultants and nursing staff may well not be well versed for example in physical conditions such as asthma, diabetes, cardiovascular, which may influence choice of treatments.**

46 **Although there have been improvements since the last Report, it is incumbent on all medical staff, at their particular level of competence, to exercise due care in the completion and regular updating of all statutory forms, as required by the MHA. *Incomplete and unrevised records present an unacceptable risk in the care of patients, as well as liability in law.***

47 ***There is a need for the further training of staff to ensure the correct completion of all the statutory forms.***

48 ***An urgent review is required of all OV patients, to identify who needs to be referred to the Mental Health Review Tribunal, including patients detained under Court order.***

49 **There is concern with the high proportion of informal patients (5 out of 13) in Dawn Ward *which deprives them of their full rights and protection under the MHA. The basis of admission of each of these patients should be re-visited and reviewed as priority.***

50 ***There is a clear need for a junior hospital doctor on the premises to supplement existing arrangements of on call medical cover by consultant physicians, as and when required, which falls short of a minimum requirement for the physical health and safety of in-patients.***

Activity and Rehabilitation

51 ***It is a matter of regret that, one year on, the unserviceable, dilapidated transport vehicle has yet to be replaced.*** **Organised outings for patients into the community are effective and clearly worthwhile. The availability of a vehicle for use at short notice is also of much importance to staff in cases of urgent, short-notice needs.**

52 **The Activity and Rehabilitation Centre (ARC) requires a serious re-assessment (vide Appendix C). Redeployment of staff and new relatively inexperienced staff has had a negative impact in a variety of ways that need to be addressed.**

53 At the time of audit, patients appeared uncommunicative and unresponsive and inactive. The suggestion of an Activity Coordinator has not been taken up. Some patients declared they did not enjoy going to the ARC.

54 The only organised activity appears to be smoking; a matter of concern raised last year and which continues. Resources for activities other than a television set appear scarce. Some patients feel they are experiencing many restrictions, particularly in being allowed out into the garden. It appears that activities such as cooking had stopped for lack of staff.

55 Audit was told the Occupational Therapy was only available one day a week.

56 A Music Therapy student attends twice a week and is proving helpful in enabling patients to re-enact their traumas and work towards their resolution. This activity should be increased and encouraged.

57 It was encouraging to find that the Rock Flats are being fully utilised. The Kent House flat is also being used, with the two patients receiving round-the-clock care. These moves to re-integrate individuals into society are very welcome.

Maintenance

58 Routine normal upkeep and maintenance revolves round a single individual expected to be a jack-of-all- trades. Hard-working and creative, he is scarcely sufficient to meet all the maintenance needs of such a large, working building. GJBS are technically on-call for major job requirements, but, the Horizon Ward lift, for example, has been out of action for over-two months. This lift allows access to the garden which is now denied to patients.

59 Cleanliness does not appear to be an issue on any of the floors, though there is an observation that they might assist in promptly identifying simple issues such as fallen curtains, or piece of furniture needing repair, so that such matters are dealt with quickly.

60 There was one complaint that cleaning staff seemed to be waiting around at the 5 pm dinner so ready to clear up that any opportunity for an extra portion was lost.

61 It would appear there are often delays in the provision of services such as laundry which may be of major significance for patients who have no families.

ADDENDUM TO THE MHB's

ANNUAL INSPECTION REPORT – 2020

The COVID 19 pandemic brought about an abrupt and unprecedented halt to consultations, dialogue, and procedures, over a significant period, that would otherwise have naturally flowed from the MHB Audit. It was felt necessary, in order to present a more up-to-date record, to provide this Addendum to the 2020 Report.

Since the Audit there has been positive change in the most difficult circumstances resulting from the pandemic. Mental Health Management and Staff should be commended for having maintained a service in these circumstances, and for their success in protecting all under their care, particularly in-patients, from Covid-19, out of the public eye and main thrust of community concern.

Following the meeting at the Ministry on 7 August 2020, it was agreed to add an Addendum recording progress made since the May 2020 Audit. Initial findings were shared and discussed with Senior Mental Health Managers and others, with changes initiated or implemented as a result.

It was noted there are now four legal firms in Gibraltar active in the field of Mental Health Law. It is crucial to avoid Gibraltar following the UK experience after the Mental Health Act 1983 was implemented: a flood of litigation.

REVIEW OF RECOMMENDATIONS IN THE LIGHT OF PROGRESS MADE SINCE THE AUDIT

1. Mental Health Act training has to be carried out by staff groups separately, e.g. scrutineers by themselves; Responsible Officers separately; Ward nursing staff on their own; Pharmacists individually; Approved Mental Health Professionals alone; and Administrators solely. Such training needs to be sanctioned and time dedicated to it.
   This has agreed, but cannot yet be implanted because of Covid-19. It will be carried out by local experts, and as advised above, to start in September. This is additional to the in-house training already up and running.

2. An s12 Approved List must be prepared and published in the Gazette. The Minister can delegate this function to the Mental Health Board and add to its function that of s12 Approval Panel.
   It has been agreed to proceed as above as soon as the Code of Practice has been approved.

3. An updated definitive Code of Practice needs to be made available urgently.
   The Code of Practice will be finalised soon and can then be approved.

4. All staff must be 'reminded' of their duties under the Act and the consequences of failing to comply with it.
   It is expected that Recommendation (1) will address and resolve this.

5. A statutory time limit should be set for Mental Health Act Tribunal appeals to be determined.
   The volume of MHRT hearings is such that no change can be effected until manpower and other issues are addressed. It is not viable for Tribunal Members - all volunteers - to dedicate on average two full working days a week to Tribunal work. It is hoped to address this in a joint meeting with the Justice and Health Ministers.

6. The work of the Mental Health Board, Second Opinion Appointed Doctor and the Mental Health Review Tribunal are becoming increasingly onerous and amount to a heavy commitment in time. These functions need to be adequately supported in the discharge of their statutory duties. It is not possible to continue relying on volunteers for such onerous functions.
   A short list of proposed additional MHB members was put forward. It is hoped to address this in a joint meeting with the Justice and Health Ministers.

7. Implementation of the Mental Health Act 2016 is time consuming and allowance should be made in Job Descriptions for these additional duties.
   This item needs to be addressed via HR and the appropriate Directorates.

8. The statutory function of the Mental Health Board in monitoring implementation of the Act and the maintenance of standards in patient care must be enhanced by additional powers, to include enforcement.
   It is hoped that the Code of Practice may resolve this issue.

9. The involvement of the Minister in the continuing process of implementation of and compliance with the Act would be a major advantage and greatly facilitated by regular meetings with the Mental Health Board.
   This has already been implemented with very positive results. Ongoing meetings will take place regularly.

10. The high number of deliberate self-harm cases in Gibraltar needs to be addressed urgently as a Confidential Enquiry.
    This item has been discussed with the Minister and advice from the Director of the National Enquiry into Suicide and Safety in Mental Health, and who leads the National Suicide Prevention Strategy for England, will be sought.

11. Particularly urgent is the implementation of a Lithium Clinic alongside the Clozaril Clinic.
    This has now been implemented and is expected to become fully functional by September.

12. Assessments of capacity and valid consent or refusal to consent must be recorded in detail in the medical records for each such detained patient. The record must include details of the explanation given to the patient, including stating the names, purpose, benefits, possible side-effects and risks of the proposed medication.
    This item has been discussed and it was agreed that it has staff implications. to be addressed via HR and the appropriate Directorates.

13. Responsible Clinicians must be required to attend Mental Health Review Tribunals hearings to give evidence and be available to be cross-examined by the legal representative for the patient.
    Attendance by RC has started to happen and it is hoped will expand with time. Again, it has staff implications.

14. The issue of ongoing physical health care of the in-patients, including a mandatory full medical history and physical examination on admission, was highlighted. The twice-weekly visits by consultant physicians does not fully address these concerns.
    The possible secondment of GPs with an interest in psychiatry to OV and CMHT clinics would be looked into in order to address concerns.

MENTAL HEALTH BOARD REPORT 2020 – Appendix A

MEMBERS OF THE MENTAL HEALTH BOARD

Government Notice No. 674 – 23rd April 2018

Mr. Julio J. Alcantara (Chairman)

Mr. George Parody

Mr. Kenneth Navas

Dr. Rene Beguelin

Dr. David Pariente

Ms. Emily Adamberry Olivero

Ms. Michele Walsh (May 2019)

Ms MariCarmen Lia (May 2019)

MENTAL HEALTH BOARD REPORT 2020 – Appendix B

An audit of Dawn Ward was conducted as follows on 24 February 2020. This is a Rehabilitation ward, and the intention was to look at cases of patients who may have been in hospital for a long period already.

Section A

1. A review of the basis for admission of each patient, to include a review of the statutory forms completed under the Mental Health Act.

There were at the time of inspection 13 patients in Dawn Ward, not including Rock Flats.

Of those, 5 were there informally, 3 were there under Court Order, and 5 were detained under the Mental Health Act ("the Act").

We reviewed section papers for all those patients detained under the Act and identified the following issues listed below, although generally compliance with the requirements was adequate, and GPs appear to be indicating more frequently where they are not section 12 approved doctors.

- **Incorrect completion of forms – for example, the H2 form, Part 4, should be signed to acknowledge receipt by the GHA – this was not done in some instances.**
- **There were some potential breaches in terms of timing where sections were granted in terms of the dates for reports by medical practitioners.**
- **There was an instance of section papers being incorrectly completed, and then a second set was completed unnecessarily given that by then there was a court order in place so that the section 3 detention was of no relevance. This may have resulted in improper permission being granted to the patient to temporarily leave hospital in breach of a court order.**
- **Some patients went from a s4 to a s3, when a s4 can only be converted to a s2. There are also patients placed directly on s3 when they should first be on a s2 for assessment.**

This was a review of a limited number of section papers only, but the Mental Health Board reiterates the importance of correct completion of forms, as well as the need for training for staff submitting forms, and we recommend the appointment of an outside scrutineer.

We were also concerned with the very high proportion of informal patients on the long stay ward which deprives them of their full rights/protections under the Act and advise that the basis of admission of each patient be reviewed as it did not appear from our own lay assessment that all of those in hospital informally should in fact be there on that basis.

2. A review of the use of statutory forms pursuant to Regulation 18 of the of the Mental Health (General) Regulations 2018.

In summary, a T2 is to be used for patients under section where the patient is able to consent to treatment. For those who do not consent, then a T3 is required, which can only be completed by a second opinion doctor reviewing the patient who is able to certify that the person is not capable of consenting, or that having capacity, they have not consented, but that it is appropriate to administer that treatment.

Of the 13 patients in Dawn Ward we found the following:

- **There were 4 completed T3 forms.**

- **There was a T4 form when a T2 should have been used instead.**
- **Our discussion with patients suggested that those on T3 had correctly been assessed as not having capacity to understand what medication they were taking.**
- **The completed T3 forms at times fail to specify which of the two categories the patient falls in i.e. whether the patient is incapable of understanding, or whether it is that the patient is capable of understanding but does not consent, and practitioners should be reminded that the appropriate (a) or (b) selection must be made.**
- **There were 4 patients on T2s. Of these, one patient stated they were completely unaware of why they were in hospital, did not understand with, or agree that they had any mental health issues for which they would take medication and were only able to recollect taking some medication for physical health conditions. This patient was therefore in our view incorrectly on a T2 and the patient needs to be assessed by a second opinion doctor to ensure that the appropriate safeguards are met.**
- **Since the visit, there have been two referrals to the SOAD for T3s; one was in a competent patient; the other in a patient previously certified as competent by the RC but who had been considered by the Board not to be competent, and who could not have had capacity in November or at any time since admission due to irreversible dementia.**

3. An interview with each patient

We met with patients privately without any nurses or medical practitioners in attendance. Of the 13 patients in Dawn Ward, 11 spoke to us; 2 declined.

Of those patients who met with us, we asked them questions to assist in making a lay assessment of capacity, to include asking them why they were in hospital and whether they took any medication, as well as inviting them to comment generally on the standard of nursing care, whether they took part in any occupational therapy activities and about things like food. We also observed the facilities available on the ward.

We found that all but 2 of the patients who spoke to us were complimentary about the standard of food, and said they enjoyed their meals.

The facilities available on the ward include one small room with a television and another room designated as a "quiet room". There is also communal seating in a corridor. Given the long term stay of the majority of these patients, it may be beneficial to have additional television facilities to provide a further source of leisure for patients, particularly as some patients are unable to leave hospital at all.

Of those who took part in occupational therapy in the area commonly known as the Arc , they largely said they went to use the computers or to colour in. It may also be that colouring activities could be made available on the ward. Some patients said they did not enjoy going to the Arc at all, and others said they would love to be able to exercise. The only organised activity for a large group seemed to be smoking, which we have already highlighted as an area of concern in our first audit report.

In relation to nursing care, the reviews were mixed; there were suggestions that nursing response was often slow and/or uncaring.

We asked patients about whether they had any physical health concerns and what assistance they got with these. Most patients had numerous physical health issues and were unsure what help they were getting for them; it is a fact that patients with mental health issues are often failed when it comes to their physical health problems, and therefore this is an area that requires much better control, with regular GP visits and in particular, continuity in the care received so that patients are better protected. A GP who is familiar with his or her patients will

much better be able to identify concerns, or even potential adverse interactions in medication than care provided by a series of different doctors.

In relation to cleanliness in communal areas, we did not identify any major concerns; however, it appears that there were delays in the provision of things like laundry services which may be of major significance for patients who have no family. We would also recommend that auxiliary staff promptly identify any issues such as for example curtains which have fallen or rips in furniture so that damage can be repaired or rectified as soon as possible and thereby prevent further damage occurring.

Section B

Guardianship under the Mental Health Act

Under sections 7 of the Mental Health Act, a guardianship application may be made in respect of a patient on the grounds that:

(a) he is suffering from mental disorder of a nature or degree which warrants his reception into guardianship under this section;

(b) it is necessary in the interests of the welfare of the patient or for the protection of patients that the patient should be so received. The person named as a guardian may be either the Care Agency or any other person provided that such application is accepted on behalf of that person by the Care Agency.

The effect of such application is to give powers to the guardian regarding decisions about the patient's residence, attendance for medical treatment, occupation and education or training and the power to require access to any patient by approved medical practitioners. Where the Care Agency is appointed as a guardian, pursuant to regulation 14 of the Mental Health (General) Regulations 2018, the Care Agency shall arrange for every patient to be visited at such intervals as the Care Agency may decide but in any case at intervals of not more than three months, with at least one visit every year to be made by an approved practitioner.

We requested conformation from the clinical manager regarding the use of the guardianship provisions in the Mental Health Act. It appears that the concept of guardianship has so far only arisen in cases where a patient has been transferred from the Care Agency where they are under guardianship. There may however be cases of patients in hospital informally who would benefit from a guardianship application and we would encourage the Authority to consider these provisions and work with the Care Agency to see how best to protect patients under the Mental Health Act.

Further, a review should be carried out where patients do not have a "nearest relative" under the Act, and consideration should be given to the appointment of a guardian or under section 38 of the Mental Health Act. In turn, this would protect the welfare of such patients, for example under the Mental Health (General) Regulations, or under section 105 of the Mental Health Act which provides that where a person who is subject to guardianship or where the functions of nearest relative have been transferred to the Care Agency, the Care Agency shall arrange for visits to be made to him on behalf of the Care Agency.

Section C

Court of Protection/access to legal advice

We would also recommend that the Ocean Views clinical (*and general*)manager be provided with direct access to a legal advice on some aspects of the Mental Health Act to assist the clinical (*and general)* manager with certain administrative matters. For example, we were made aware

that patients sometimes have money made available to them, possibly via social security payments, although this aspect was unclear. There may be potential issues with some patients being vulnerable to financial abuse or simply loss of funds from point of collection to return at Ocean Views; some patients might require Court of Protection deputies but it is not clear what arrangements are in place to deal with this.

Further, this money is held on site, in *(central)* safe, but this practice has resulted in monies belonging to deceased patients being left in that safe indefinitely. It may be that monies are in fact bona vacantia, but the clinical manager would require legal guidance in terms of making an application for letters of administration and so on, and in our view it would be beneficial to the service as a whole to establish a mechanism by which such legal advice can be requested directly from public sector legal advisors.

Section D

Mental Health Review Tribunal

We make further recommendations in relation to the Mental Health Review Tribunal.

1. Part 6 of the Mental Health Act established a Mental Health Review Tribunal to deal with applications under the provisions of the Act. Section 91 sets out the applications which may be made under the Act. For the purposes of this report, we will focus on applications to be made under:

- **s91(1)a) where a patient is admitted to a hospital in pursuance of an application for admission for assessment (i.e. under section 2 of the Act);**
- **s 91(1)(b) where a patient is admitted to a hospital in pursuance of an application for admission for treatment (i.e. under section 3 of the Act);**

2. Patients sectioned under s 2 of the Act can make an application to the Tribunal within 14 days of admission. Patients detained under s 3 of the Act can make an application within 6 months of admission. Staff at Dawn Ward informed us that they provide information to patients as to their rights under the Act. We did not find any information on patient files showing that this was the case, but equally have no reason to doubt that information.

3. However, we did identify a breach of the Act in that pursuant to section 93, the Authority has an obligation to refer cases to the Tribunal as follows:

4. Under s 93(1)(a), a patient who is admitted to hospital for assessment under section 2 or under s 93(1)(b) a patient who is admitted to hospital for treatment under s 3 must be referred to the Tribunal on expiry of the period of 6 months beginning with the applicable day. The only exception is where a patient has already been an application themselves under section 91. From our enquiries at the Tribunal, it is clear that the Authority is not referring patients as necessary. There is a further obligation to refer where a period of more than three years has elapsed since his case was last considered by the Tribunal whether on the patient's own application or otherwise.

5. We therefore recommend that an urgent review be carried out of all patients in Ocean Views, and of patients subject to community treatment orders, to ensure that the Authority is not only advising patients of their rights under the Mental Health Act, but also ensuring that it complies with its duty to refer patients directly to the Tribunal. This is a crucial part of the legislative provisions designed to ensure that patients are not detained unlawfully. We would also emphasise that patients are entitled to legal representation at the Tribunal and patients should be given reasonable assistance to seek and secure such representation; for example, this could

include providing a list of suitably qualified lawyers, and allowing patients access to their lawyers in person and by telephone.

6. Separately, for those detained under Court Order, it seems to us that an urgent review of this position is required, in order to ensure that patients are not held unnecessarily by virtue of staff not being made aware of orders having expired. Although we are not aware of any such case, it is apparent that those detained by court order are unclear and unsure as to their future release, and as these patients do not appear to have legal representation, and in some cases may not have relatives either, we are concerned that their rights are not being protected when it comes to the question of their future release.

<u>Summary of recommendations</u>

1. Urgent review of all patients in Ocean Views to identify who needs to be referred to the Mental Health Review Tribunal, to include patients detained under court order;

2. Further training of staff required to ensure correct completion of statutory forms;

3. Further review of occupational health facilities particularly for long term stay patients;

4. Further review of nursing response time and nursing interaction with patients;

5. Dedicated legal support to be provided to Ocean Views for clinical (*and general*) manager.

Michele Walsh – Kenneth Navas

MENTAL HEALTH BOARD REPORT 2020 – Appendix C

Ocean Views Audit Report 2020. The ARC (Activity & Rehabilitation Centre) and Dawn Ward

A year on from the last audit has seen significant changes in the ARC, which contrasts sharply with the buoyant and optimistic situation which was encountered last year.

Suffice to say that following an incident last August, some of the staff were re-deployed and new staff taken on board to avoid closure of facility. It also resulted in the loss of an OT Technician and an enrolled nurse. The problem was augmented by the long term absence of senior staff covered by relatively inexperienced member of staff. The Nursing Assistants also needed extra supervision.

The result of this has had a negative impact on the activities carried out by the Centre and a subsequent reduction on Community support.

Included is a timetable of activities from both years so comparisons can be made. (Annex i) Please note that the 4 Music Therapy sessions a week this year are taken by a student.

Groups were now also smaller to reflect the changes in staff.

It was also stated that initiatives like the Breakfast Club have not proved successful. This initiative would involve the patients from the rehabilitation flats and was part of their rehabilitation programme for increasing their skills and independence and providing structure to their days. It was initially run on Mondays and Tuesdays (Beginning Monday 7th October 2019) and the hope was that it would take place every week day. Unfortunately, the uptake on this has been poor for reasons that are beyond the knowledge of this audit. (See Annex ii Breakfast Club information sheet)

In a later conversation in Dawn Ward, it was clear that the lack of take up on the Breakfast Club was not common knowledge. Clearly lack of communication seems evident, at least in this case.

It was reported by the Senior OT that lack of staffing had had a negative impact on attendance at MDT meetings and since September/October 2019, attendance had been difficult. It was also observed that meetings did not always start on time and this also impacted on the service users in the ARC.

The bus has also not been replaced and is now, not surprisingly, not used at all. At our last meeting with the Hon. Neil Costa, before the last election, it was argued that we could not understand why Ocean Views had to rely on an unsuitable 25-year-old bus, when just across the wall, Bella Vista boasted a fleet of state of the art transport facilities. A year on and the situation remains the same. This needs to change.

On a more positive note, we spoke to a Music Therapy student, who is working two days a week in the ARC. Unlike the conventional idea of music for relaxation, the use of music here is to enable patients to enact their traumas and hopefully find a resolution. (Annex iii Music Therapy notes)

In last year's audit it was argued that an Activity Coordinator might be the answer to coordinate activities in Dawn Ward to bridge the gap between the ward and the ARC, but this has not happened and later when this was suggested to a senior member of Dawn Ward, it was not something that he thought was needed. Likewise, in going over the staffing issue he confirmed that the current levels were sufficient; a contrast to last year's views by other members of staff.

During the visit the patients were uncommunicative, unresponsive and simply sitting around doing absolutely nothing, except staring at the TV. Exactly the same as last year.

Similarly, as last year, the issue of smoking breaks and how life seemed to revolve around it was brought up. Looking at the situation today, nothing really has changed.

However, unlike last year the Rock flats are being fully utilised and this is encouraging. The flat at Kent House is also occupied by two patients who have round the clock care. There are also plans to move patients to Sandpits, a new facility. Anything which involves the re-integration of these individuals into society has to be positive and this move is very welcome.

Sunshine Ward

Conversations were held with members of staff to get a flavour of the ward and to establish if there were any patients in the same situation as XX, a patient who had needed a Court of Protection order. Unfortunately, the latter's case had taken nearly 2 years to resolve and only weeks ago had been transferred to Mount Alvernia.

They were not able to ascertain the exact number, but we were informed that the Mental Health Matron was in the process of preparing a database with all the necessary information. This is a step in the right direction and should make life much easier for everyone, who find themselves in the same position as XX. Hopefully it would take much less time and establish a protocol for these kinds of patients.

In seeking information on some patients it was discovered that some of them had been institutionalised since the 1960s. Clearly information on their next of kin was not up to date and the process of updating the records was put in motion.

As the patients here are elderly and wheelchair bound, the issue of resources and especially wheelchairs came up in discussion. In an unused corridor there were quite a number of wheelchairs that were clearly unserviceable. The issue here is that these elderly patients are wheelchair bound and the wheelchair is an essential part of their lives. The concern expressed was that requests for repairs or replacements took far too long. It would make sense to ensure that this process be speeded up so that these elderly residents can sit in comfort and be able to be moved around.

The bathroom has a bath fixed to the floor and it was very difficult for members of staff to bend down to help the patients. There is a hydraulic bath on the market, which would make life much easier for patients and staff. Again, this a matter to consider when looking at resourcing the facility.

YY is an articulate gentleman, who clearly seemed to have sufficient capacity and wanted to get a haircut, but the barber had stopped going a while back and there were no provisions in place. I spoke to a member of staff who explained that he had been told to get three quotes from different barbers and then they would choose. Because only one had replied the process had ground to a standstill. It is understandable when there is a large Government Project involved, but for a haircut, it just seems ludicrous.

Code of Practice

In-house training is extremely important if anything is ever to work efficiently in an organisation. It is the life blood through which information is shared with all participants.

To this end it was crucial to see the provisions in place to continue to educate and bring up to speed the staff on the MHA's Code of Practice.

The document has gone through several re-writes, but we have been lead to believe it will be ready in late March, pending approval. Nevertheless, the previous version is a good starting point as it is the manual that unlocks the MHA in practical ways and gives staff a better understanding of their duties and responsibilities.

It was encouraging to talk to the organizer of the sessions and see how the programme will develop.

The sessions will begin with the Nursing Assistants (Approx. 20). These sessions will take a month to complete and will begin in Late March, early April.

In mid-June it would be the turn of the Qualified (33) and Enrolled Nurses (19)

There are also plans to work with Clinical Managers at St. Bernard's on the Mental Health Act itself. This will most probably happen sometime in March.

As always with these kind of initiatives, they work well enough on paper, but the proof of the pudding, will be its practical results and I look forward to the evaluation of the course and its follow up. It would be very interesting to talk to some of those taking part and see if the Code of Practice has made a difference to the way they perceive their role.

This is a positive initiative, which needs to be given all the support necessary to be an effective tool in raising awareness of the implications of the Mental Health Act 2016.

<u>Recommendations</u>

- ✓ **The staffing situation at the ARC needs to be addressed and the complement brought up to the level previous to September 2019.**
- ✓ **Communications between the ARC and Dawn Ward needs to be strengthened and developed.**
- ✓ **As was stated last year the ward should appoint an Activities Coordinator to liaise between the ARC and the ward. Unfortunately, like last year, there were few activities taking place in the ward, other than patients staring at the TV.**
- ✓ **The smoking issue has not been revisited and remains the same.**
- ✓ **MDT meetings needed to be organised so that it is possible for everyone concerned to attend.**
- ✓ **Similarly, timings should be kept to as much as possible.**
- ✓ **Unfortunately, the bus has not been replaced and it thus becomes more difficult to take patients out.**
- ✓ **Activities like the Music Therapy sessions need to be increased and encouraged.**
- ✓ **It is also very positive to see more use of the Rock flats and those in the community. This is the way forward.**
- ✓ **Equipment in Sunshine Ward should be repaired quickly and spares be available in case the repairs take too long.**
- ✓ **A hydraulic bath should be installed in Sunshine ward.**
- ✓ **Services like hair dressers etc. should be simplified for the benefit of the patients.**
- ✓ **The Code of Practice is the essential manual to enable staff to unlock the MHA. It is encouraging for this to beginning to take place. This is crucial and needs to be given a high level of priority**
- ✓ **No provisions have made for a larger room in A & E to cater for patients exhibiting psychotic behaviour. This should be made available.**
- ✓ **There is an issue when admitting patients, who are not resident or undocumented. There has to be a clear, practical and efficient protocol to deal with such patients so that problems can be resolved effectively for all concerned.**
- ✓ **Notwithstanding the merits of local inspections, future audits should be carried out by the same body, which audits UK facilities. The Care Quality Commission (Independent Regulator of Health and Social Care in England) has the professional expertise to carry out a full inspection. These they do in force and over a longer period**

RC

Timetable for

Dated 10/06/2019

Monday	Tuesday	Wednesday	Thursday	Friday
Arc Session 10-12	Community Skills Group in Casemates 10.30-12pm	Aviary Group 10-12	Cooking Group 10-1.30pm	Community Skills Group in Casemates 10.30-12pm
Community Visits	Baking session 10-12	Pamper Group 10-12		From 14th June to attend the Beach outing to Western Beach until the end of August
	Arc Session 10-12	Mens cooking session 12-130pm	Arc Session 2-3.45pm	Arc Session 2-3.45pm
		Afternoon Sessions		
Bus Ride 2-3.45pm	Community Visits	Community Visits	Bus Ride 2-3.45pm	Community Visits
Arc Session 2-3.45pm	Arc Session 2-3.45pm	Arc Session 2-3.45pm	Arc Session 2-3.45pm	Arc Session 2-3.45pm

(Annex-i)

RC
ACTIVITY & REHABILITATION CENTRE

Dated 19/02/20

Monday	Tuesday	Wednesday	Thursday	Friday
Breakfast Club 8.30-9.30am	Breakfast Club 8.30-9.30am		Cooking Group 10-1.30pm	Community Skills Group in Casemates 10.30-12pm
Individual Session 10-12 Music Therapy Individual session	Out and About Group 10-12	Baking session 10-12		
Arc Session 10-12	Music Therapy (Sunshine Ward) 10-11am	Home visits/Individual session 10-12		
Afternoon Sessions				
Aviary group 1.45pm	Community Visits		Social Afternoon 2-3.45pm	Aviary group 1.45pm
Music Therapy 1.30-2pm	Arc Session 2-3.45pm	Pamper Group 2-3.45pm		Social Afternoon 2-3.45pm
Shopping Group 2-3.45pm	Music Therapy Individual session 2-3pm			

(Annex ii)

Occupational Therapy

ARC Department

Breakfast Club

This group is available for clients in the rehabilitation flats, and should be seen as part of their rehabilitation programme for increasing their skills and independence and providing structure to their days.

It will initially run on Mondays and Tuesdays, starting next week (Mon 7th October 2019). It is hoped that it will build up to take place every day from Monday to Friday.

How will it run?

The group will be facilitated by Arc and ward staff.

Clients from the rehabilitation flats are expected to be encouraged to attend as part of their programmes.

They should be dressed and ready to come between 8.30-9.30am.

The session will take place in the OT kitchen.

Breakfast will be prepared/cooked individually by the clients, and staff will be expected to join in, chatting, eating and being involved together.

Each client will be expected to talk through their plans for the day and week, involving the staff to discuss what they need to get done to progress forward.

See attached a daily sheet to encourage discussion and help with planning for the day/week.

Breakfast Club

What are my plans for today?

For example

Shower

Laundry

Clean my room

OT sessions

Pay bills/collect benefits

What are my plans for the week?

For example

Go to clubhouse

Go to the OT sessions

Out for coffee/ lunch

Meet friends/family

How can the staff help me?

For example

Help me with my laundry

Help me with cooking

Attend 'cook my own lunch' sessions

Help me look after myself

Help with sorting out my bills/ money

(Annex-iii)

Information about music therapy.

Music therapy is an established psychological clinical intervention, which is delivered by HCPC registered music therapists to help people whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs.

Central to how music therapy works is the therapeutic relationship that is established and developed, through engagement in live musical interaction and play between a therapist and client.

A wide range of musical styles and instruments can be used, including the voice, and the music is often improvised.

Using music in this way enables clients to create their own unique musical language in which to explore and connect with the world and express themselves.

Who can benefit?

Music therapists frequently work as members of multi-disciplinary teams in health, education, social care or in private practice. They deal with:

- Children and young people
- Learning disabilities
- Autistic spectrum conditions
- Mental health care
- Older people
- Neuro disability

Because music participation and response does not depend on the ability to speak, music therapy is a particularly effective clinical intervention for people who have difficulty communicating verbally.

For people affected by disability, illness or injury, working with music-therapists can be life-changing.

Children with autism can develop emotional, social and communication skills.

Someone with an acquired brain injury as the result of an accident can be helped to regain their speech.

An older person frightened by the isolation and confusion brought on by dementia can, through the powerfully evocative nature of music, connect with these memories again and share these with others.

Everyone has the ability to respond to music, and music therapy uses this connection to facilitate positive changes in emotional wellbeing and communication through the engagement in live musical interaction between client and therapist.

It can help develop and facilitate communication skills, improve self-confidence and independence, enhance self-awareness and awareness of others, improve concentration and attention skills.

MENTAL HEALTH BOARD REPORT 2020 – Appendix D

Focus of team composed of 3 persons:

- Availability and quality of non-psychiatric medical care for patients; mainly those with other acute medical problems; (Dr R Beguelin OBE)

- Patient well-being and their perspective; discharge programmes; (Emily Adamberry Olivero MBE)

- Patient care, well-being, and related areas; (Marie Carmen Lia)

The following is a collection of findings and comments made by both staff and patients. When there has been more than one person voicing a similar issue, the repetition has been included in this list.

MEDICAL ISSUES

- **Chiropodist, visits every second Tuesday and has 12 appointment slots for toenail or hand nail clipping.**

- **Consultant Physician visits twice a week beginning and end of week. A book is kept on each of the 3 main wards - Sunshine Ward, Dawn Ward and Horizon Ward with Sky Ward incorporated into the Horizon Book. Unless something significant is treated there is usually no entry in the patients notes by the consultant but there is almost always a mention of the intervention in the nursing notes. All these appointments are recorded with chronological entries for each intervention by the visiting physician for that day.**

- **There are no routine admission physical medical examinations, which is a cause for concern, as there is no junior medical staff to perform these, and the nursing and psychiatric consultant staff may not be well versed in medical conditions like diabetes, asthma, hypertension, chronic obstructive airways disease, chronic renal and cardiovascular conditions which would all be flagged up and influence the choice of treatments available to the Consultant Psychiatrists..**

- **Medical emergencies - when severe (collapse, unwitnessed fall etc.)are dealt with by calling an ambulance team who will see and treat or transfer the patient to the main hospital Accident and Emergency Department. Other less acute conditions are prioritised by – the Consultant Physician to see at their next visit, and they can be contacted at all times for advice and help or even an unscheduled visit. There is a clear need for a junior hospital doctor on the premises to supplement the existing service which falls short of the minimum requirements of care for the physical health and safety of the in-patients.**

- **Emergency dental care is available at St Bernard's Hospital but this is limited to extractions and acute infection and pain control with no preventative, reconstructive or prosthetic dental treatments.**

- **Optician available on request. Ophthalmology department optometrists attend on request from the staff if they notice difficulty with vision.**

- **Diabetic Nurse Specialist also available on request but this service is very stretched at the moment. Diabetes Type 2 is a common complication of long term antipsychotic medication and there are several inpatients who are insulin dependent. The two new DNS's have been recruited by the GHA but will not start work until May 2020.**

Summary and Conclusions on Medical Issues

Although most common medical needs are catered for in a reasonably timely manner, there is clear unanimity from staff, nurses and doctors about the need for junior or non-consultant medical staff in order to cater for in-patients day to day medical problems. Most importantly the lack of a thorough physical examination at the time of admission is very unsatisfactory as critical medical problems could be overlooked or ignored with serious consequences for the safety of the patient and would affect the choice of psychiatric treatment.

<u>Staffing issues</u>

Unfortunately with specialisation on Psychiatric nurses there are fewer nurses available with training in basic nursing skills and this is an area where further training should be provided for minor ailments.

Another unsatisfactory issue was that on occasions appointments were being made within the service without this being advertised internally to give opportunities to interested parties to submit an expression of interest. (*Management states that this is incorrect – posts are advertised internally for expressions of interest)*

<u>Risk assessment Issues</u>

On occasions a nurse has been required to escort a patient (on a 1-1 basis) to the main hospital for treatment. However if the patient decides to leave or run off there is not much that the nurse can do to stop them, especially if it's a minor. We were informed that 1:1 nursing should not last more than 2 hours without relief and for no more than 3 hours for any one shift. Some had experienced being on escort duty without relief for up to 12 hours at a time which was unacceptable and hazardous.

<u>Informal patients</u>

Informal patients are under represented

Many patients require to be assessed under the Mental Capacity Act and whether they should be under DOLS (Deprivation of Liberty)

THE PATIENTS PERSPECTIVE - Comments and complaints

- **Patients on Sections get preferences – informal patients are very low on the list of priorities;**
- **Patients feel that they are experiencing many restrictions such as not being allowed to go out to the garden and wonder whether this is allowed;**
- **They feel that sometimes the medication is not given and then they are asked to sign that medication was omitted;**
- **A Patient complained that in the past they had been locked out and left in the garden twice;**
- **A few patients complained that when they were having trouble sleeping at night and fancied a hot drink they were not allowed or even provided with hot water to make their own drink;**
- **Another patient complained that his room had been searched in his absence and objected to this as he felt he should be present during this time;**
- **A patient complained that he was unable to visit his young daughter outside hospital due to lack of availability of escort;**
- **In Horizon Ward the lift which allows access to the garden so that they can have a smoking break has not been working for over 2 months. This was depriving the patients of a certain degree of independence which they were used to when the lift was functioning;**
- **Additionally they felt there was a need to be able to communicate with the ward from this garden area especially in the event of distress or emergencies. An intercom would resolve this, as on many occasions individuals had wanted to leave this area and were unable to do so until somebody turned up of their own accord or as previously arranged.**
- **Several patients complained that on many occasions their food was cold but staff would not assist with warming food in the microwave nor take any responsibility for this due to doubts on recommended temperatures for food. The result being that patients with mobility problems and those that ate late had to put up with cold food.**
- **They also felt that there was lack of personal care as on occasions when a person was in his room isolated nobody bothered to ask how they were feeling.**
- **When asked if they had a named nurse – the response was that there was not much difference between their named nurse or any other nurse**
- **The patients felt there was a lack of activities – there was only TV. When asked what activities they would like, they mentioned cooking and music but this was not available due to lack of staff.**

- Apparently a workshop for those with disabilities had been requested by the OT but GHA did not approve this.
- OT was only allowed on Thursdays;
- Another patient complained about the unavailability of a hot drink in the early hours
- Another complaint was the inability of use their telephones or wifi;
- As regards dinner at 5pm the cleaners are waiting around to clear up and if you relaxed your guard the food and everything around was cleared up so quickly that you lost the opportunity to have an extra portion if you were hungry.
- Regarding personal needs – a person's prescribed medication for dry skin was not respected nor replenished by the hospital which left patient very uncomfortable and irritated.
- Patients felt that if they complained or had a disagreement there were repercussions
- Another patient complained that what they desired was a plate of hot food but they had been told that it was not legal to heat food in a microwave.
- A recurring comment from patients was that they did not feel that they got much attention. Even when the complaint was put in writing to the hospital manager not even an acknowledgement had been received;
- Another patient commented that there were no activities and nobody asking how you felt not even a key nurse;
- Another patient commented that when he was feeling suicidal he was told to wait 10 minutes but in the end there was a delay of 5 hours which was neither helpful nor reassuring. This patient mentioned he had actually overdosed on several occasions in the past even thought he was unaware why he did this – yet he was not taken seriously which seemed very surprising.
- A patient felt that nurses had been great when she reached a crisis however she had not been offered any talking treatments and her psychologist was off sick – she was on medication

<u>Care Plans</u>

Care Plans were only available for patients in Dawn Ward.

All of them were clearly typed and dated mid February – most were due for a review in a month time. It gave the impression that this issue had been recently addressed as this was sadly lacking last year. The files did not show any previous care plans giving the impression that this was the first written detailed formalized plan on file.

One patient's file (which was the exception) showed a previous care plan dated October 2019 which said 'To be reviewed monthly '. The next Care Plan was dated February 2020

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

Summary and Conclusions on Medical Issues

Although most common medical needs are catered for in a reasonably timely manner, there is clear unanimity from staff from nurses and doctors about the need for junior or non-consultant medical staff in order to cater for in-patients day to day medical problems. Most importantly the lack of a thorough physical examination at the time of admission is very unsatisfactory as critical medical problems could be overlooked or ignored with serious consequences for the safety of the patient and would affect the choice of psychiatric treatment.

Summary and Conclusions on Patient Care Issues

This is the summary of the findings in the audit carried out on February 2020 in Ocean Views.

There was a common thread of complaints that personal needs were being overlooked e.g. lack of communication with a designated nurse so that the patient can discuss perceived needs be they physical, psychological or emotional.

The patients feel unable to raise issues such as food being "coldish" when it gets to them and despite having a microwave there is no one available to reheat it.

Food is taken away before they are offered a second helping even when this is available.

Often during late night or early morning, a patient would benefit from a warm drink but this "cannot "be provided.

Another issue of complaint was that their privacy was not being respected e.g. their cupboards and lockers are searched without their permission or presence.

In general patients seemed dissatisfied with the daily attention they receive on a personal basis. They feel they are not being listened to and where there is difference of opinion between a patient and a member of staff, the patients feel that the staff "stick" together.

Overall patients feel victimised. Boredom does not help their psychological welfare as activities are limited to television, which is controlled by the staff.

Basically there is a perceived feeling of lack of empathy although it was mentioned that "young" patients do appear to get more attention.

Due to the above, patients are unhappy with the basic nursing care they receive.

Recommendations on Patient Care:-

Most of the above could be improved with an increase of nursing staff with basic nursing skills who could act as patient advocate and reporting to the qualified nurses in charge.

Dr. Rene Beguelin, Emily Adamberry Olivero, Mari Carmen Lia

MENTAL HEALTH BOARD REPORT 2020 – Appendix E

COMPLIANCE WITH AND PRACTICAL IMPLEMENTATION OF MENTAL HEALTH ACT 2016

The requirements of the Mental Health Act 2016 at the practical level have not been adequately implemented and much work remains to be done to achieve even the minimum sufficient standard. Compliance with the Act is poor.

Mental health staff complain of difficulties with the Act and it is clear that there is a lack of knowledge and understanding of the requirements. Mental health staff of all grades requested additional training, as the previous training sessions failed to meet the need at a clinical and practical level. I have offered to undertake this training but it has not been possible to seek approval yet because of the Covid-19 emergency.

The failures to implement the requirements of the Act at an adequate level are compounded by the fact that (1) A s12 Approved Doctor List has still not been published by the Minister, as required by the Act. (2) The Code of Practice remains in draft form, is based on a discarded England Mental Health Act 1983 version containing now illegal practises (e.g. in contravention of the European Court Bournewood decision). A definitive and up-to-date version is urgently required.

The consequences, as examples, are (1) Patients have been sectioned by two doctors, none of which was s12 Approved, though the Act requires that one must be s12 Approved. (2) Relatives not meeting the requirements of the Act have been recorded as Nearest Relative within the meaning of the Act. (3) Detention under s4 has converted into a s3 when it can only be converted to a s2. (4) Community treatment Orders have ceased to be used, as the first four failed to meet the requirements of the Act. (5) Patients lacking capacity are 'detained' informally in breach of the European Court of Human Rights decisions, thereby being deprived of the protection of the Act. (6) All Mental Health Act documentation is required to be scrutinised but, when audited , it is clear that the scrutineer has regularly failed to detect irregularities and even illegalities, and the scrutiny amounted to rubber stamping only. (7) Sections are not uncommonly allowed to lapse, but patients continue being detained , despite the failure to renew the section. (8) There are very long delays in Mental Health Review Tribunal appeals being heard, even as long as nearly two years. (9)The Consent to Treatment requirements of the Act have, for all intents and purposes, virtually fallen into disuse, as compliance is very poor.

CONSENT TO TREATMENT

Part 3 of the Mental Health Act 2016, s44 to 54, states that the treatment of a patient who has been detained for three months requires valid consent or a second opinion from a Second Opinion Appointed Doctor. Since September 2019 to mid-May 2020 there have only been four referrals for a second opinion, all from the same Responsible Clinician, but none form the other four Responsible Clinicians. These four referrals are a tiny fraction of those in the same period in 2018-2019.

The Audits carried out by the Mental Health Board have repeatedly detected patients lacking capacity certified as consenting; patients requiring a second opinion not being referred, but medication continued regardless; and those who have a Second Opinion Appointed Doctor Consent to Treatment T3 Certificate being illegally prescribed and administered medication not authorised by that Certificate.

It is a common experience that patients appealing to the Mental Health Review Tribunal having been detained for over three months but are lacking a Certificate of Consent to Treatment, either a T2 or a T3.

Each discipline is equally and severally responsible in law for the implementation of the Consent to Treatment requirements of the Act: Responsible Clinicians for prescribing, pharmacists for dispensing and nursing staff for administering only medication that is authorised by the Consent to Treatment Certificate. Yet, this is largely disregarded by all three disciplines.
In the absence of a lawful Certificate of Consent to Treatment a prescription is unlawful and must not be dispensed by Pharmacy or administered by a nurse.

Invariably there is no assessment of capacity on record in the medical notes; or an assessment of valid consent. There are never details of the explanation given to the patient of the proposed treatment. Patients certified as having consented often lack capacity and, with the exception of one single case in the past two years, never receive an adequate explanation of the proposed treatment. Assessments of capacity and valid consent or refusal to consent must be recorded in detail in the medical records for each such detained patient. The record must include details of the explanation given to the patient, including stating the name, purpose, benefits, possible side-effects and risks of the proposed medication. The correct form required by law must be completed, but is not always the case.

It is accepted that assessing capacity and obtaining legally valid consent is very time consuming and requires specialised training in the Lasting Powers of Attorney and Capacity Act. It is recognised that Responsible Clinicians have not been given dedicated time to meet all these additional requirements.

RECOMMENDATIONS

1. **Mental Health Act training has to be carried out by staff groups separately, e.g. scrutineers by themselves; Responsible Officers separately; Ward nursing staff on their own; Pharmacists individually; Approved Mental Health Professionals alone; and Administrators solely. Such training needs to be sanctioned and time dedicated to it.**
2. **An s12 Approved List must be prepared and published in the Gazette. The Minister can delegate this function to the Mental Health Board and add to its function that of s12 Approval Panel.**
3. **An updated definitive Code of Practice needs to be made available urgently.**
4. **All staff must be 'reminded' of their duties under the Act and the consequences of failing to comply with it.**
5. **A statutory time limit should be set for Mental Health Act Tribunal appeals to be determined.**
6. **The work of the Mental Health Board, Second Opinion Appointed Doctor and the Mental Health Review Tribunal are becoming increasingly onerous and amount to a heavy commitment in time. These functions need to be adequately supported in the discharge of their statutory duties. It is not possible to continue relying on volunteers for such onerous functions.**
7. **Implementation of the Mental Health Act 2016 is time consuming and allowance should be made in Job Descriptions for these additional duties.**
8. **The statutory function of the Mental Health Board in monitoring implementation of the Act and the maintenance of standards in patient care must be enhanced by additional powers, to include enforcement.**

9. **The involvement of the Minister in the continuing process of implementation of and compliance with the Act would be a major advantage and greatly facilitated by regular meetings with the Mental Health Board.**
10. **The high number of deliberate self-harm cases in Gibraltar needs to be addressed urgently as a Confidential Enquiry.**
11. **The recommendations made by the Mental Health Board in the First Report have not received attention. Particularly urgent is the implementation of a Lithium Clinic alongside the Clozaril Clinic.**
12. **Assessments of capacity and valid consent or refusal to consent must be recorded in detail in the medical records for each such detained patient. The record must include details of the explanation given to the patient, including stating the names, purpose, benefits, possible side-effects and risks of the proposed medication.**
13. **Responsible Clinicians must be required to attend Mental Health Review Tribunals hearings to give evidence and be available to be cross-examined by the legal representative for the patient.**

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