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ISLE OF MAN
MENTAL HEALTH
COMMISSION

Report on Announced Visit to Mannanan Court on March 29th 2022.

The Mental Health Commission made an announced visit to the In-patient unit on Tuesday 29th March 2022.

The visiting team comprised 2 professional members, Dr. Malar Babu Sandilyan, and Dr. Richard Hillier and 3 lay members, Ms. Samantha Pearson, Mr. Paul Kane and Mr. Ian Buxton (chair). This was the Commission's first visit with 2 of the 3 new lay members in attendance. Apologies were received from Mr. Patrick Swanney who attended the preparation meeting but was unable to attend the visit as he required to be off island.

Pre-visit documentation requests were met in good time but arrived separately. The MHC would like to work with Manx Care to standardise the request and coordinate the delivery of reports in advance of future visits to be more efficient.

Pre-visit Meeting with Management

At the start of the visit, the Commission met with management staff. Present were General Manager Integrated Mental Health Service, Mental Health Act Manager, Senior Nurse, Care Quality and Safety Coordinator, Operational Manager Adult Mental Health Services, Mental Health Directorate, Ward Manager and Matron, IMHS.

A short discussion took place about the significant impact of the recent wave of COVID infections on the service due to the Omicron variant.

The National Collaborative Commissioning Unit visit report was provided and this was received with thanks by the chair and will be reviewed at the next MHC meeting on June 27th.

A discussion about the use of hospital transfers to move patients from Manannan Court to Noble's Hospital took place. Standard practice to date has been to use the hospital transfer to move patients between the two IoM hospitals. This would appear to be the correct process on first inspection, however this process requires the receiving hospital to have a Psychiatrist. The hospital transfer process is normally used to transfer patients between different mental health hospitals in the UK. This is an administrative issue and at no time were any patients' detentions either unlawful or fell away as a matter of this process, given the MHAO and Consultants always continued to be involved. In the case of short term treatment, the correct way to transfer a patient to Noble's would be to use S.17 leave from Manannan Court to Noble's Hospital. Management agreed that the custom and practice of using Hospital Transfer process would be stopped and S.17 would be used in future.

Mr. Buxton summarised an incident with a patient at the prison that required their transfer to the UK for specialist treatment. Mr. Buxton thanked the management team for their diligence, care and perseverance in finding an appropriate place for treatment. Mental ill health and personality disorders requiring hospitalisation within the prison are infrequent and this had led to some confusion about timescales to provide treatment in the UK and also as to why Manannan Court was an unsuitable location. Mr. Buxton agreed to arrange a meeting with General Manager Integrated Mental Health Services and the Independent Monitoring Board of the IoM Prison to improve understanding about the challenges of the provision of treatment in the UK and to share best practices.

General Observations and Environment

Occupancy

Harbour	**Glen**
Section 3: 8 patients	8 Patients*
Section 2: 2 patients	
Informal: 3 patients	S.17 Leave: 1 patient
Empty beds: 3	

*The information as to which section the Glen suite patients were on was unclear from the board in the office.

Ward Environment Observations

The patient storage area was visited and a significant improvement was noted in the orderly storage of patient's belongings compared to previous visits. This is a significant improvement in the respect for patient's belongings. This was discussed with a member of staff who expressed that patients arrive with bin bags of belongings and it can be chaotic. There could be an opportunity to educate staff and develop increased empathy about the disruption to social norms that can occur with mental illness e.g. limited belongings always carried, no permanent home etc.

A number of the activity rooms were found to be cluttered with furniture which was apparently due to actions taken during Covid to remove furniture from the dining room to encourage social distancing. Several rooms therefore remain out of commission at a time when the ward has been very busy. Alternative storage could perhaps have been found during the 2 years the pandemic has been ongoing to store the furniture and return the rooms to service.

The ward appeared clean, but there are signs of some wear and tear – for example broken observation window to one of the rooms on the Glen Ward which was currently boarded up (this has been reported) and the seclusion suite is in need of re-painting.
One nurse stated that she felt there were too many interview rooms and that there is a plan for some of these to be repurposed.

The sensory room remains unfinished, which has been remarked upon in previous reports. The Commission would like to see a plan for completion with timing.

Clinic and staff areas were cluttered and untidy, this was mentioned in previous report but has not been addressed though we can empathise that the ward is under significant duress from the impact of Covid. The introduction of 5S method could help staff maintain this and improve their wellbeing at work. The 5S method is a housekeeping process where all staff own the standard to keep order using Sort, Set in order, Shine, Standardise, Sustain. It has become common practice in many industries with shared workspaces and different staff shifts.

There are plans to make the activity room in Glen Ward more accessible for those patients with dementia, the MHC look forward to reviewing this once completed. The ward appeared to be a pleasant environment and was tidy. A wall hanging showing the date was observed, this might also benefit patients in Harbour Ward as one patient was struggling to remember the date.
An Occupational Therapist is being appointed, the timing will depend on the recruitment and onboarding process.

Glen ward – Patient Physical health

We visited the Glen ward and spoke to the Registered nurse, especially focusing on staff attitudes towards physical health needs of frail and older patients.

We were assured the National Early Warning Score (NEWS assessment) is in place for all patients and that the NEWS observations are carried out every day. The challenge remains for those patients who refuse or are too aggressive to cooperate with the physical observations. The hospital is looking into alternative observations for such patients (visual checks).

We looked at the NEWS folder, there were gaps evident in some areas. This was explained by patients refusing or being very agitated and hence it was not always possible to get those checks done. The nurse explained there are regular falls incidents on the ward, and we did note at least two patients had moderate amounts of sedative drugs (benzodiazepines, pregabalin) prescribed, the nurse assured the medical team reviews these on a weekly basis and medication is adjusted based on patient needs. The MHC note from shared reports that falls incidents are recorded via Datix and that falls with harm (moderate / severe) have a very low occurrence rate.

The nurse stated they feel confident that there is timely medical input available and nursing team is supported by doctors when they are requested to review patients. We would like to see how patients' falls risk is assessed (upon admission and hereafter) and how the care plan is drawn to reduce falls (for example, there are sensors attached to patient beds to detect movement).
There is now an activity coordinator which will help in patients overall care.

There has been an incident where a patient had to be transferred to the acute hospital and since had passed away and this is being looked into separately in detail, we would like to see the action plan and learning from this incident in due course.

There still remains a gap in training as nurses don't seem to be confident in their own abilities to recognise and support patients with complex physical health needs, especially in Glen ward. This is an area that needs imminent attention and we would like to see some action points on this area.

It is concerning that even mandatory training such as Basic Life Saving and Intermediate Life Saving are not being kept up to date by staff. Staff shortages and training on hold during Covid were cited as the predominant reasons. We will review this in subsequent visits.

Legal Paperwork and Admission Papers

Section 132

All of the patients who were detained under section 132 had an outcome within the stipulated 72 hours, there is significant reduction in the waiting time to be assessed by the ASW which is an improvement over previous visits. There also is a prompt medical review by one doctor and the ASW soon after the patient arrives at 132 suite and if need be, referred on to a formal MHA assessment which also has helped in reducing the waiting time. There has only been three episodes where the waiting time has exceeded 10 hours and this is usually because the person is intoxicated, one of them had timely interventions by the medics and had treatment prescribed for alcohol withdrawal, which is good practice. The 132 suite also appeared clean and suitably furnished to contain agitated patients.

Drug Cards and form 46 / 47

There were in total 10 detained patients on Harbour suite and two detained patients in Glen suite on the day of inspection. Four patients (three from Harbour suite and one from Glen ward) were requiring their consent to treatment to be considered under Part 4 of the mental health act.

The first patient had an additional antidepressant prescribed on the drug card which was not covered by form 46 (SOAD form), capacity for the patient was duly assessed and documented. The second patient had promethazine prescribed on the drug card which was not covered by the form 46; also was prescribed zopiclone on the drug card but only zolpidem was authorised on form 46. The third patient had all their medication prescribed compliant with what was authorised on form 47 and capacity assessments were done. The patient on Glen ward had a form 46 uploaded on Rio but this was not attached to the drug card, all medication prescribed on the drug card were authorised by form 46.

We shared this information to the relevant doctors and ward manager during our visit , we would urge the ward pharmacist to regularly audit the forms to make sure the medication are in compliance with the form 46 and 47.

Admissions Paperwork, Capacity and Rights

There were twelve patients on section that were reviewed. Ten on Harbour and two on Glen. One patient on each of the wards was on Section 2 and the rest were on Section 3. The longest detained patient had been detained since Q3/2020, with a complex organic psychiatric condition and it had been difficult to find suitable accommodation for them. Two others had been detained for just over a year, but most, six, had been detained earlier in March 2022.

For six of the twelve patients, the section papers had been completed satisfactorily. Five patients had been detained as posing a risk to others whilst that risk was not described in the section papers. For three the mental disorder was not described. This could be a training issue, but it could be an issue due to a perceived lack of space on the statutory forms. Whilst the form cannot be changed, the doctors can write further explanations on continuation sheets.

There was generally good recording in the progress notes of attempts to explain the patients' rights under the MHA, and it was recorded when the patient appeared no to be able to understand the information. There was generally an attempt to try again recorded in the notes if this were the case. Consent to treatment forms had been completed or SOAD referrals made for patients detained longer than three months. On occasion it was not possible to find details of the discussion that led to a consent to treatment (form 46) being completed to say that patient did have capacity to consent to their treatment.

Mental Health Review Tribunals

Under section 76 of the MHA 98 the hospital managers are required by law to refer patient to the MHRT where the patient has not made an appeal application within the first 6 months of detention. This should be made within the first 7 days of the renewed detention as stated in the code of practice. The MHC were able to find evidence that this had occurred within the stated timeframe. There was evidence that referrals had been made to tribunals after the first renewals of detentions. No patients were detained long enough to require subsequent renewals. There has been some delay in convening the tribunals occurring over 2020 and 2021 it may be that these delays affected how quickly tribunals occurred after renewals of detention. The delay was outside the review and application process.

Associate Hospital Managers Hearing

During a patients detention under section 2 or 3 of the MHA 98 patients are entitled to request a review of the detention at any time. This is separate from the renewal process which is heard automatically upon the consultant reviewing the patients' detention and deciding if a further detention is required. The MHC were able to find evidence that referrals had been made upon renewal to Managers' Hearings.

Section 17 Leave

Section 17 leave forms were complete and up to date for all patients except the one patient on leave to Noble's Hospital acute ward. As we discussed, there has been some misuse of Section 19 to transfer patients to Noble's Hospital, rather the correct procedure of granting Section 17 leave to the hospital wards.

Summary of legal paperwork review

The following table summarises the review of legal paperwork and highlights areas of concern with clear explanations in patient's notes and with recording the understanding of their rights.

Checklist for Consultant Psychiatrist responsible for Medical Scrutiny of admission Section Papers.					
29/03/2022					
	Section 2	3			
	Section 3	10			
		NO	Yes	N/A	
1	An explicit statement about the presence of a named **mental disorder** and the reasons for believing this.	3	9		
2	**Descriptions** of degree and / or nature of the mental disorder that warranted 24 hour hospital detention under the care of a Responsible Clinician.	1	11		
3	Reasons for 24 hour hospital detention and why a less restrictive option (management in the community) was not possible.	0	12		
4	Reasons why informal admission was not justified.	0	12		
5	If the Doctor stated that detention was in the interest of the patient's **health**, clear reasons why.	0	12		
6	If the Doctor stated that detention was in the interest of the patient's **safety**, clear reasons why.	1	11		
7	If the Doctor stated that detention was necessary for the **protection of others**, clear reasons why.	5	3	4	
Record of MHA rights explained by staff S128 form					
1	On admission	3 Attempts	8 recorded	1 Attempted but not listened to	
2	Second opportunity	3 Not recorded	2 Recorded	1 Not recorded on renewal	
Checklist for Consent to treatment & SOAD approval.					
1	Is the detention longer than 3 months?	8	4		
2	Has form 46, consent to treatment, form been completed by RC?		2 Recorded		
3	Has the discussion about consent to treatment been recorded?	1	1 recorded		
4	Has a SOAD been contacted?		2 Recorded	1 N/A	1 Not Found
5	Has a form 47 been completed by a SOAD?		2 Recorded	1 N/A	1 Not found
Section Renewal					
1	Date of renewal		2 noted		
2	Referral to MHRT - S76		3 noted		
3	Date of Tribunal Hearing		4 noted		
Section 17 Leave form (current)					
1	Has S17 leave been granted?	3	8	1 transfer to Nobles	
2	Is the form current and in date?	0	8	3 N/A	1 not found
Notes		Progress notes mention S2 or S3 randomly	S17 was rescinded due to non compliance	Maybe there is some confusion ofer how to transfer to Noble's on S17 leave	

Review of use of Seclusion

We visited the seclusion suite which was adjacent to 132 suite in Harbour. The room itself has two parts- the de-escalation area and then the locked seclusion area, which has glass doors to enable continuous observation. The room is clean and tidy with minimal furniture to reduce risks that can be an issue with agitated patients who would require seclusion.

There are paper forms for each multidisciplinary team review (8 hourly review should be an independent review) and nursing assessments which are done 2, 4 and 8 hourly during the seclusion, the paper documents which we were told will usually be uploaded on to Rio, however it was not found on Rio documentation. We were told there are separate audits that were being done for seclusion monitoring, and we would like to see those audit results and action plan.

There have been eight seclusion episodes since our last visit, one patient requiring three seclusion periods between 12-2-22 to 15-2-22. From Rio progress notes it is apparent that immediately after seclusion the doctors are informed, nearest relative and MHC also informed duly.

There are regular reviews conducted to observe the patients during their period of seclusion as evidenced by nursing and medical entries during these seclusion episodes. Overall the level of monitoring and reviews seem to be in line with the seclusion statutory requirements and policy.

There are two incidents that we would like to highlight as raising cause for concern:

1. A patient during the period of seclusion required rapid tranquilisation and was restrained in prone (face down) position and administered the medication. Generally prone restraints are discouraged and this patient was intoxicated too which further increases the risk of cardiorespiratory distress- we would request if this incident be looked into further by the PMVA lead.

2. A patient who was placed on section 5(4) and immediately required seclusion, however this then expired leaving the patient as informal whilst still being secluded till the next day. From Rio it appears one medical recommendation was done in view of pursuing section 2 detention, but the patient was not eventually detained. The patient was in seclusion which is a highly restrictive environment whilst being an informal patient. The legal basis for detention in seclusion for an informal patient should be reviewed.

Interviews with Staff

We met with 2 nursing staff during this visit.

An interesting observation was made about the impact of the Manx Care hospital estate-wide ban on smoking. “The patients with S.17 leave permitted request short leave six to seven times per day and this leads to a risk assessment each time and is considered a waste of time that could be better used for nursing”.

Safety was felt to be better compared to the UK with fewer incidents of patients harming others.
An incident was described where “a S.4 was used to return a patient from the café to the ward where a S.132 would be correct.”. The Mental Health Act office subsequently confirmed this was actually S.5(4) under best interests as the patient had agreed to informal admission but upon going up to the ward became hostile and wanting to leave to self-harm.

When discussing teamwork, it was described that support is offered to Glen ward but this is not reciprocated. Glen staff had allegedly refused to help during periods of isolation.

We discussed the handover process, the policy is good but is not felt to be being followed properly. e.g. patient missed MRI, this was not on shift handover or Rio or diary. A rigorous handover should include SBAR – Situation, Background, Assessment and Recommendation for each other.

Staffing has been a challenge for the last month both for skill mix and quantity of staff. Recruiting is a challenge and is impacted by house prices in IoM. Training gaps exist including resuscitation and intermediate life support.

Some safety concerns have been raised and escalated and received response.
The observation regime is taking more positive risk.

Sharing of information is low. Care planning is improving but is a work in progress. A dislike for RIO was expressed compared to PARIS.

The team is good but is drifting and has been manager-less for a while. Staff feel valued and listened to. Staffing was discussed, two qualified staff may mean one is newly qualified (Preceptorship) and that there are not always sufficient staff for S.17 leave to be carried out.

Patient Interviews

Several patients agreed to interview during this visit and we met with the spouse of one patient.
An interview with one patient was difficult due to their condition, however when more relaxed they described they were looked after well.

Patient comments are reported, it should be noted that MHC lay members are not medically trained and able to judge the patient's state of health or accuracy of statements that may not be contemporaneous.

Legal rights

One patient indicated that their rights had been explained but that a paper copy had not been replaced. Access to management review and tribunal was mentioned.

It was stated boy one patient that they understands their rights, but they noticed some other patients have had this in written form in a welcome pack and recovery map. They too would have liked this.

One patient stated they were aware of tribunal and their rights, however they seemed to be unsure about their right to a second opinion from another doctor. The patient has sent a complaint to Manx Care and while an acknowledgement was received they stated that they are still waiting for a reply for more than 20 days. The patient described their relationship with their consultant psychiatrist as difficult.

Nursing care and staff attitudes

One patient described that they did not get along with their first named nurse. Another named nurse was allocated and the patient now has a better relationship with the new nurse.

A patient reported that staff at times seem tired due to short staffing and this has manifested as some staff being on a short fuse at times.

At times patients have observed that the ward can be noisy when patients are trying to rest. Also it was expressed that the more seriously disturbed patients seemed to receive more staff attention.

One patient reported that on one occasion, after an act of deliberate self-harm, a staff member seemed impatient with them whilst cutting a ligature that the patient had tied.

A patient described that some nurses do not seem to display a caring attitude and that they could not access their care plan without speaking with their named nurse. An example of this problem was given as: an incident in which the patient described that they had missed the time for going for medication and was told by the nurse "If you don't come for the meds then you don't get it".

One patient described that during a period in Isolation with Covid, on 2 of those nights no medication was provided. The patient said that the staff told them that they forgot due to their being in isolation.
A patient described being woken in the morning by a nurse switching the lights on and pulling the covers off.

The visibility of nurses on the ward was discussed, the patient stated that the nurses generally sit in the office and the HCAs seem to be doing "all the jobs".

Issues with privacy and dignity such as staff shouting out medication names in front of other patients were mentioned and that they have previously seen someone being showered by staff with the door open. The patient described reporting an incident to staff and reported that nurses laughed at this.

A patient also reported being upset when they witnessed a racist patient not being challenged by staff.

One patient reported that their access to leave could be forfeit if they do not engage in therapeutic activities.

Access to therapies

A patient described having regular access the psychology services, but that they had to change therapists due to not finding one therapist's style of working compatible.

One patient stated they are unhappy that there are is no access locally to a DBT group, although they have met with the psychologist. The Patient said that they understand that there are people in the ward with lots of different illnesses but reported feeling upset and frustrated that some patients will have to be sent elsewhere for appropriate treatment. The patient said that they are faced with a very difficult and uncertain time if they are sent off island for treatment and that they will be unable to see their young children. Opportunities to stay in touch with their children have been offered, including the travel costs will be paid for their children. However the patient felt that this did not feel reasonable, as the children would have to travel a long distance.

Food

One patient described it taking what in their opinion was an excessive amount of time for the ward to arrange a diet that took into account their multiple food allergies.
One patient stated that the food was ok for hospital food and could be worse. However they find the menu repetitive.

Visits

A patient described that it is difficult to arrange visits when on high level observations as there is only one room on the ward for visits and if this is already in use then those on high level observations cannot go downstairs to the café for a visit. The patient did note that staff have been flexible with visiting times.

Activities

One patient expressed concern that the activity coordinators are leaving imminently and is concerned that there will be a further reduction in activities that have already reduced markedly. When activities are on offer, the patient enjoys painting, colouring, art, mindfulness, pamper sessions and going on a walk with a member of staff.

One patient described the activities as poor and said that this was an issue even before Covid. The Patient felt the craft activity which was put on today was for the benefit of the inspection as the usual activity offered would be colouring in. The patient said that both activity coordinators are leaving so this is likely to get worse. The patient has kept themselves busy with study.

Physical Health Needs

A patient remarked that they believed that physical conditions are not understood well by nursing staff. On one occasion, a physical need was identified but did not lead to appropriate care until the evening and the patient reported that there was some confusion between staff and the patient that occurred on the next shift but this was resolved later.

We met with the spouse of a patient that had been admitted on S.2. The patient's spouse expressed some specific areas of concern regarding the admission, treatment of physical needs, transfer to Noble's and over use of sedation.

On admission, they reported that their spouse's long term physical medication for constipation had been stopped, without adequate consultation as to why the patient was taking it. There was also some delay to treat other physical conditions, such as swollen legs and feet.

The spouse's other concern was that when they had reported that their partner's level of sedation was excessive, the staff appeared not to listen. Eventually this sedation led to the patient needing to be transferred to Noble's Hospital. The spouse's concern was that although they had spotted the problem before the ward staff, the staff did not seem to listen to her or take her concern seriously.

Accommodation and ward environment

One patient feels that mixed sex wards are inappropriate, this should perhaps be reviewed as part of a strategic review of provision of therapies not currently available in Manannan Court.

One patient finds the ward to be very loud and this is hard, especially at night. Patient described there being lots of 'kick offs' including other patients punching walls and kicking doors in the corridors.

End of visit meeting with management

Mr. Buxton summarised the visit and identified a number of positive observations but noted there were more concerns identified than in previous recent visits. It was noted that this may pertain to the additional stress the unit staff are under due to the latest impact from the Covid pandemic in the Isle of Man.

The professional members summarised their findings and highlighted that physical needs were an area requiring further support until the next generation of nurses progress through this training.

During the management debrief we spoke with the RMO about the patient with several physical needs on admission. The response appeared defensive and challenged what he described as 'interference of the spouse'. The professional members and the chair felt the response of the RMO to the spouse could have been more supportive and worked to build a relationship as they have a medical background and play a key role in patient recovery. While we understand the statement that the RMO made about the urgency to stabilise the patient's mental condition and avoid interaction with other medication we feel this explanation could have been given to the spouse with more empathy for them and the patient's physical needs.

The Mental Health Commission would like to thank staff for their help and co-operation during the announced visit.

Summary

This was again a positive visit, the management team remain open to feedback on both positive observations and areas for improvement. There was evidence of the stress that the unit had been under due to the impact of Covid on staffing and the extraordinary effort they had all made to maintain safe operation of the unit for vulnerable patients.

Positive observations:

- Staffing levels were maintained at safe levels despite severe impact from Covid.
- The extraordinary level of effort by staff to maintain the service during Covid was noted.
- Improved storage and tidiness of patients' belongings.
- Plans to make the ward more dementia friendly.
- S.132 shows improvement.

Areas of concern observed:

Priority concern areas

- The understanding of physical needs of patients is a concern on both wards.
    - Use of NEWS system and monitoring the physical needs of patients.
    - Staff confidence in assessing physical needs
- Seclusion episodes need closer scrutiny to be fully compliant. Two incidents were highlighted for further review and we would like to review the findings.
- Medical cards and Form 46/47 needs further scrutiny and increased awareness for prescribing doctors.
- BLS and ILS training needs urgent attention.

Other concerns

- Minor correction to use of Mental Health Act, patient transfer to Noble's has used hospital transfer (S.19), rather than S.17 leave.
- Some patient records have details of their condition omitted.
- Staff and patients have reported some shift handover issues.
- Patients have reported a decrease in empathy from staff, examples include actions or statements they may have perceived as negative consequence or "punishment" e.g. removal of leave.
- Some rooms were out of commission due to furniture storage that could have been stored elsewhere after a period of time.
- The sensory room remains unfinished and an update with timeframe for completion is requested.
- The activities for patients remain limited and we are concerned that the activity co-ordinator role(s) will be unstaffed in the near future and that activities for patients will be limited further.
- Food and diet remains a concern for some patients especially variety for vegetarian and vegan diets and for longer stay patients due to repetitiveness.
- Some patient needs indicate the strategic need to review DBT provision on the Isle of Man
    - An acute ward may not be the best environment for these patients
    - The need to be treated in the UK is a large burden for patients with young families
- Gender appropriate support should be provided for patients undergoing therapy for trauma.