2018

External Review of Guernsey Adult Mental Health Service

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Report of external review of safety and quality of adult mental health service

I was asked by Dr Nicola Brink, Director of Public Health, to undertake a brief review of the adult mental health (AMH) service to provide a view about the quality and safety of the service and advise about any immediate actions that should be undertaken. I set out my findings in this report following a three day visit to review the adult mental health service provided by the Guernsey HSC.

Methodology

The findings are based on interviews with some clinicians and managers of the service including the governance team as well as the consultant from the emergency department. I also had interviews with the directors of the service and HSC. I did not interview medical staff from the mental health service due to an ongoing investigation.

I visited Oberlands centre including Crevichon Ward. In addition during a tour of the building I spoke to staff from the recovery and rehabilitation team, psychology team and the duty team. I saw the emergency department where mental-health patients can present in emergencies.

I reviewed the recent incident data relating to the mental health service. I was also able to review the activity data relating to inpatient admissions including detentions under Guernsey Mental Health Law 2010 for the year up to April 2017.

I was shown the TRAK system which is currently used for recording risk assessments and care plans.

I did not review operational policies.

Findings

My overall impression is that a good service for mentally ill patients is being provided for the population of Guernsey and Alderney. In general, mental health services are high risk services and when incidents arise it is important to learn from them and also consider them in the context of the quality and safety of the overall service. It is positive that HSC has commissioned this review of quality and safety. It demonstrates an openness and transparency as well as a desire to learn from incidents.

I was impressed by the commitment and dedication of the clinical and managerial staff that I encountered. I was also impressed with the quality of the building and environment at the Oberlands centre. In my view Crevichon ward offers a state of the art environment for the delivery of care for acutely mentally ill patients. It provides an environment that has been designed to be ligature free.

My impression is that the AMH service is well resourced with a number of teams providing inpatient, outpatient and community care to the population.

There is a well-resourced support and counselling system in place for staff undergoing formal processes. These include automatic referral to Occupational health, counselling, pastoral oversight and off-island treatment if required.

There is excellent work already underway on improving the systems and processes around admissions to Crevichon ward. These include but are not exclusive to the following important areas:-

- The admission process is being improved to ensure that there is a joint medical and nursing assessment of risk and care planning to manage clinical risk.
- Policies are being reviewed updated and/or developed stop this includes the observation policy and consideration of the levels of observation.
- The handover process has been clarified in writing.
- There is now a robust induction process that is based on a competency based framework.
- Resuscitation training/simulation.
- An important area of development centres on nursing leadership and development within the ward to ensure that nurses are aware and capable of adopting accountability and responsibility in accordance with their roles.

Areas for consideration for further work/development

1. Emotionally unstable personality disorder: understanding of the disorder and provision of care

I was informed by staff that there are a significant number of patients within the service who meet the criteria for a diagnosis of emotionally unstable personality disorder (EUPD). These patients can be challenging and demanding to work with and sometimes elicit negative feelings in those providing care and also within the community.

It is important that there is an awareness and understanding amongst clinicians of the aetiological factors involved in the development of personality disorder which typically include significant trauma in their early years. I recommend on-island multidisciplinary training for all staff within AMH on EUPD to improve understanding of the disorder and foster a positive, non-judgemental approach to those who present with the diagnosis. It is important that staff from the emergency department are included as they play a crucial role in providing care to these patients at times of crisis.

I also recommend that a comprehensive, joined up service for these patients is developed with multidisciplinary working across teams which should provide the following elements:-

- 'containment' through allocation of a community key worker, typically a community psychiatric nurse, who would maintain weekly monitoring and oversight of the patient's mental health. This sense of containment is important for people with EUPD and ideally would be the person they would link with at times of crisis. The keyworker would also act as a point of contact for carers particularly at times of concern.

- Specialist therapy in the form of Dialectical Behaviour Therapy (DBT). There is a strong evidence base for the effectiveness of DBT in patients with personality disorder. This therapy is already available within the CAMHS service and in my view should be provided within the adult mental health service. The decider skills group which is provided by the recovery and well-being team is in no respect a substitute for evidence-based intensive DBT.

- Psychiatric review of mental state and backup when required.

- 3 to 6 monthly multidisciplinary reviews of the care plan involving the patient and their carer.

2. Ligature free environments in all areas where high-risk suicidal patients are cared for.

Acutely unwell, high-risk, suicidal patients present at the emergency department. Within the last few weeks a patient has tried to ligature whilst in the emergency department. It is also noteworthy that

the emergency department has been used exclusively as the 'place of safety' for those detained by the police under section 92 in the year to April 2017.

For safety reasons it is essential to have an appropriate assessment area for mentally ill patients. Currently there is no designated assessment room available which is appropriate for the safe assessment, observation and management of suicidal patients within the emergency department. There is an expectation that emergency departments have a room that is designed to be ligature free with appropriate access and exit points to enable the safe observation and management of mentally ill patients. The room should be located within the emergency department and not at a distance from the centre of the department.

Consideration also needs to be given to the inpatient facilities available for CAMHS inpatients on the paediatric ward to ensure that they can be safely managed within that environment.

3. Capacity: Training and Documentation.

There is no capacity legislation at present in Guernsey but I was told that this is under consideration and may become law at a future date. However at present clinicians refer to the absence/presence of capacity in clinical notes to justify their clinical decisions. In the UK there is an expectation that comments on capacity are underpinned by a recorded assessment of capacity. I attach for information (Appendix 1) a typical mental capacity assessment template that is used in the UK.

In the absence of an underpinning legislative framework it is difficult to justify a full blown training programme on capacity. However in the meantime consideration should be given to improving clinicians' understanding on capacity and how this should be recorded in clinical notes.

4. Integrated working across teams in adult mental health

All adult mental health teams are based at Oberlands Centre. Despite the opportunity this close proximity provides there is currently a tendency for teams to work in silos. Consideration should be given to developing and embedding a culture of integrated working across disciplines and teams, leading to true multidisciplinary care and thereby enhancing the quality of care for patients. For example, it is generally accepted that multidisciplinary input to the discharge planning process on inpatient wards enhances safety by improving the follow up arrangements for patients.

5. Acute inpatient provision on Crevichon ward

The 'acute' ward has 17 beds with low levels of acuity. The activity data demonstrates that admissions and rates of detention have fallen over the past few years with less off island placements and this is likely to be related to the development of the Oberlands Centre and the reorganisation of the service following its' opening.

It is reported that ward staff sometimes have difficulty caring for challenging patients. This is likely to be related to low levels of acuity leading to complacency and loss of skills in managing high-risk, demanding patients. Low acuity levels may also lead to an expectation amongst staff that this should be the norm. This is an area that needs to be monitored on an ongoing basis to ensure that inpatient staff have the competencies to manage acutely mentally unwell patients who present with

challenging behaviours. Senior clinicians and managers may need to be extra vigilant in monitoring this on an ongoing basis.

6. Governance Issues

Mental health service is provided by the HSC alongside other health specialties. The investment in the Oberlands centre demonstrates the commitment of HSC to the mental health service in Guernsey. In everyday practice it is important that mental health services have a high profile and are valued within the overall health service at the Princess Elizabeth Hospital.

Mental health nursing with its specialist focus is perhaps poorly understood within the overall system and yet it is a key and essential element in providing high-quality safe care for mentally ill patients. It is important that mental health nursing as a specialist nursing profession has a high profile to ensure good morale but also to foster optimal standards.

Consideration should be given to developing a leadership role within mental health nursing with responsibility for professional issues. This role could also potentially be linked to the governance department thereby improving understanding and communication.

7. Assurance

It is important when an incident arises that it is considered within the context of the overall performance of that service. Therefore routine monitoring and scrutiny of quality and safety indicators is a mechanism for providing assurance on an ongoing basis. Development of a dashboard containing a set of metrics covering 4 key areas may assist in providing assurance.

The four key areas Include:-

- quality and safety (incidents, near misses, audits, prescribing/medication errors including compliance with BNF doses, falls, benchmarking data etc)
- patient/customer feedback (complaints, routine collection of customer feedback from various settings, annual survey of service users)
- workforce (turnover, sickness level, vacancy rate, staff satisfaction surveys, compliance with training requirements etc)
- use of resources/finances

The dashboard can be adapted for service level use with a more high-level dashboard being available for the HSC executive. It enables the service to demonstrate that a good service is being provided and it also allows the executive to assure itself about the quality and safety of care.

There are accreditation schemes which have been developed by the Royal College of Psychiatrists which cover various aspects of mental health care. These accreditations can be useful but are expensive and time-intensive to put in place. These could be selectively considered over time.

8. Full review of mental health services

I understand that there was a full review of services prior to the move to the Oberlands centre. There is currently a good model of care in place which contains all key elements of a good mental health service within it. I believe that with some tweaking and refinement of the way that teams operate that the quality of care provided by the mental health service would be enhanced.

In my opinion with this refinement a full service review is not necessary at this stage.

End of report

Appendix 1

Mental Capacity Assessment

Individual's details

Name:

Address:

Date of birth:

Location at time of assessment:

Decision Requiring Assessment of Mental Capacity (provide details):

Two-stage Test of Mental Capacity

a. Does the person have an impairment of mind or brain, or is there some disturbance affecting the way their brain or mind works? This disturbance can be temporary or permanent. Provide evidence:

b. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Can the person :-

a) understand the information relevant to the decision? Yes/No

b) retain that information? Yes/No

c) use or weigh that information as part of the process of making the decision? Yes/No

d) communicate his/her decision (whether by talking or any other means)? Yes/No

Provide evidence in respect of the person's ability in relation to each of these four elements of the test:

4. **Outcome of Mental Capacity Assessment**

On the balance of probabilities, there is a reasonable belief that:

The person has capacity to make this particular decision at this time.

OR

The person does not have capacity to make this particular decision at this time.

5. <u>Details of the Assessor</u>

Assessor name:

Designation:

Signature:

Date and Time: