KEY FINDINGS AND RECOMMENDATIONS MINI-REPORT OF THE NURSING CARE AND SERVICE PROVISION ON MANANNAN COURT'S HARBOUR SUITE, ISLE OF MAN

Presented to Isle of Man Government's Department of Health and Social Care

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Content

1. Introduction

1.1 This review was initially set up by The Isle of Man Government's Department of Health & Social Care, as a result of negative news media reports about the Manannan Court Acute Services.[1]

1.2 Dr Tommy Dickinson, Independent Psychiatric-Mental Health Nurse Consultant, was appointed as an independent investigator to:

A. Review the applicable policies, practices and procedures at Manannan Court's Harbour Suite;

B. Review the progress made regarding the implementation of the recommendations posited in the *Report into the Nursing Care and Service Provision at Grianagh Court Acute Inpatient Ward, Isle of Man*, by Dr Tommy Dickinson, dated September 2, 2015; and

C. Identify recommendations for further action.

2. Key findings

2.1 The observations and findings during the visit to Manannan Court's Harbour Suite reveal that many aspects have improved since the move from Grianagh Court Acute Adult In-Patient Ward. The environment appears much more fit for purpose and the safety of patients is clearly seen as a priority.

2.2 Dr Dickinson noted that work on the implementation of the 'Safewards Model' appears to have been curtailed.

2.3 It is pleasing to see that the 'Senior Practitioner' role has been decommissioned and that two individuals have been appointed to the new role of 'Ward Manager' at Manannan Court. However, Dr Dickinson feels that the operationalisation of this role is challenged.

2.4 It is encouraging to see that dialectical behaviour therapy (DBT) training is offered twice a month to staff on Harbour Suite and there is a personality disorder care pathway in development. This should be commended. Nevertheless, from the news media reports and interviews with patients and staff, it appears that some staff may still hold pejorative attitudes to people with a personality disorder. This may be owing to the emotional impact of the complicated relationship with care and caregivers that this patient group present with, especially within inpatient settings.

2.5 There appears to be reasonable progress to implement training and development regarding how to assess and manage the risk

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[1] Adrian Darbyshire 'DHSC rejects whistleblower claims on unit', *IOMToday*. January 16, 2019.

of suicide. The Mental Health Service *Policy for Risk Assessment and Management of Self-Harm and the Prevention of Suicide* has been developed. All clinical staff have had, or will be undertaking, training on the DICES® Risk Assessment and Management System.

2.6 There appears to have been improvement in the standard of record keeping and documentation. It is pleasing to see that a new policy for record keeping and documentation and an accompanying audit tool have been developed and implemented. The Acute Services Manger undertakes these audits and staff are given developmental feedback on this through management supervision.

2.7 It is pleasing to see that some staff, including those in senior leadership roles, have been internally rotated into different clinical settings, and appear to be flourishing in their new roles. However, it was reported that there are still some staff who have been on the same ward for many years. This has been shown to have a detrimental effect.[2] Individual wards can sometimes become the undisputed territory of individual staff that might have worked on them for decades and thereby define their culture. If such individuals become embittered or 'burnt out', their indifference to those in their care can be 'infectious'.[3] This may be negatively influencing individuals' attitudes towards people with a personality disorder, as described above.

2.8 On Dr Dickinson's recent visit, he was pleased to see that an evidence-based clinical supervision policy has been developed and implemented. However, all the staff that Dr Dickinson interviewed reported that they had very limited access to clinical supervision, despite supervision being offered at various times and managers offering to cover the ward to facilitate this.

2.9 Dr Dickinson was informed that a Clinical Psychologist (CP), external to the ward, has offered group supervision sessions at various times, including weekends. However, it is disappointing to see that these have been very poorly attended. Dr Dickinson noted a possible interpretation for this: some staff were critical of the CP offering clinical supervision, stating that because the CP did not work on the ward, they did not see how clinical supervision with this

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[2] See e.g. National Health Service, *Report of the Committee of Inquiry into Whittingham Hospital* (London, 1972).
[3] Eileen F. Morrison, 'The Tradition of Toughness: A Study of Nonprofessional Nursing Care in Psychiatric Settings', *Journal of Nursing Scholarship* 22 (1) (1990), pp. 32-38; John Hopton, 'Daily life in a 20th century psychiatric hospital: an oral history of Prestwich Hospital', *International History of Nursing Journal* 2 (3) (1997), pp. 27-39; John Hopton, 'Prestwich Hospital in the Twentieth Century: a case study of slow and uneven progress in the development of psychiatric care', *History of Psychiatry* (1999), pp. 349-369.

person would be beneficial. One could argue, however, that the CP's distance from the ward could offer an element of objectivity, which is beneficial in clinical supervision, especially group supervision.[4]

2.10 The care plans Dr Dickinson reviewed were poor. They did not appear to be evidence-based and there was no indication that they had been developed in collaboration with the patient.

2.11 There appeared to be little emphasis on the importance of therapeutic engagement within some care plans. Moreover, some patients reported that they had not had a 1:1 with their Named Nurse for 'weeks', despite the *Standard Operating Procedure for the Role of Named Nurse and Nursing Teams within Mental Health Inpatient Services* stating that this should be offered 'at least an hour twice weekly' (p.6).

2.12 During Dr Dickinson's visit, there appeared to be minimal occupational activities on offer for patients, as the activities co-ordinators were on leave. Nevertheless, Dr Dickinson was reassured that, with the appointment of specific activities co-ordinators and occupational therapists, there are a range of activities on offer for patients, should they wish to engage in them.

2.13 The competency of the person undertaking patients' enhanced observations needs to be assessed by the Registered Nurse (RN) delegating this duty. However, Dr Dickinson did not see evidence that the 'Clinical Observation Competency Form' was being used (a copy of this was included in Dr Dickinson's report dated September 2, 2015). Version 5 of the *Therapeutic Engagement and Observation Policy* could outline that this form is to be used as part of the process of placing a patient on enhanced observations.

2.14 The layout of Grianagh Court meant that utilising a 'Zonal Engagement & Observation Model' would not have been possible. However, this intervention does not appear to have been implemented on Harbour Suite either, despite its layout lending itself to this model.

2.15 Dr Dickinson was reassured that all policies are now available online and that there is a training package for these policies and the Acute Service Manager audits staff's completion of this training. However, Dr Dickinson did not see evidence that people from a diverse range of cultures, religions, gender identities, sexualities and minority ethnic groups were involved in assessing the impact of these policies. Additionally, he noticed that the ward relies quite heavily

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[4] See, e.g. Barbro Arvidsson, 'Psychiatric nurses' conceptions of how a group supervision programme in nursing care influences their professional competence: a 4-year follow-up study', *Journal of Nursing Management* 9 (3) (2001), pp. 161-171.

on agency staff. Therefore, consideration needs to be given to their level of training and whether this is adequate to provide safe and therapeutic care on the ward.

4.Commendations

4.1   Dr Dickinson was very impressed by the Integrated Care Project, which is being led by Paul Jackson. This should be commended.

5. Recommendations

5.1   The implementation of the Safewards Model needs to be fast-tracked. Enquiries should be made to the central Safewards team in the UK as to whether a Safewards lead could facilitate a seminar on the Isle of Man, with a view to this serving as a 'booster' to get the initiative moving as soon as possible. Contact details: info@safewards.net. There also needs to be a nominated person on the ward responsible for driving and leading the implementation of this.

5.2   Dr Dickinson welcomes the introduction of the new Ward Manager role to replace that of Senior Practitioner. However, the new role in its current form requires both managerial and clinical leadership, which makes its operationalisation challenging. These should be separated into two roles: 'Ward Manager' and 'Clinical Team Leader'. The Ward Manager could be a Band 7 responsible for ensuring high quality, safe and effective care in the inpatient setting. Overseeing the day to day running of the ward, the nurse in this role will:

- Have continuous responsibility for the ward, ensuring systems are in place for the safe delegation, monitoring and supervision of care.

- Provide professional leadership for, and management of a team of multi-professional registered and unregistered staff.

- Be responsible for the ward budgets and the safe and efficient delegation of resources.

- Be responsible for the safety of the clinical environment.

- Build the capacity and capability of the ward team through the effective planning, facilitation and delivery of education and training opportunities.

- Monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.

5.3   The Clinical Team Leader could be a Band 6 (potentially paid an additional responsibility allowance). Consideration should be given to the person appointed to this role undertaking the Royal College of Nursing Clinical Leadership Programme, which

aims to develop nurses' leadership skills using a bespoke coaching framework. The Clinical Team Leader would <u>not</u> replace the Nurse in Charge role. The nurse appointed to this role should become supervisory to the ward so that they can:

- Lead the implementation of the Safewards Model.
- Ensure the assessment, planning and evaluation of evidence-based care is carried out in line with best practice.
- Provide expert evidence-based clinical advice.
- Supervise and audit clinical care.
- Oversee and maintain nursing care standards.
- Teach clinical practice and procedures.
- Role model good professional practice and behaviours.
- Oversee the ward environment.
- Assume high visibility as the nurse leader of the ward.
- Promote an open, honest and reflective culture on the ward.

5.4   *Patients' care plans on Harbour Suite need urgent improvement.* The care plan template on RiO is not fit for purpose. An alternative personalised, recovery-focussed care plan template needs to be developed. The care plan should promote collaboration with RNs and their patients.[5] The use of laptops would enable RNs to sit with patients on the ward, to collaboratively develop them. The care plan could then be uploaded onto RiO as a live document and updated as required.

5.5   Patients who have specific risks indicated should have a robust Risk Management Care Plan for each risk identified. This should be regularly evaluated and updated, as appropriate. If a patient is placed on an enhanced level of observation, a RN should complete a Risk Management Care Plan specifying:

- The reason why they have been placed on this observation
- The risks posed from a bio-psycho-pharmaco-social (BPPS) perspective
- Detailed interventions to guide the member of staff undertaking their enhanced observations on how they can maintain the patient's and/or others safety; and
- Strategies for how they can actively therapeutically engage with the patient.

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[5] Michael Coffey, Ben Hannigan & Alan Simpson, 'Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: a cross-national comparative mixed methods study', *BMC Psychiatry* 19 (115) (2019), pp. 1-18.

A hard copy of the Risk Management Care Plan should be attached to the 'Observation Recording Form', so that it is easily accessible.

Dr Dickinson noted that Version 5 of the *Therapeutic Engagement and Observation Policy* requires RNs to develop a Risk Management Care Plan, which specifies the above points when a patient's observation level increases. *The ratification of this policy should be fast tracked.*

5.6 Improving the physical health of patients with serious mental illness is pertinent.[6] Therefore, all patients on Harbour Suite should have physical health care plans. Understanding of biological causes of challenging behaviour is crucial, especially regarding reactive psychiatric symptoms and behavioural responses to pain, fear, infection or chronic disease. Patients with mental health problems may be particularly prone to exhibiting challenging behaviour as a result of a biological aetiology.[7] Therefore, all patients should be assessed by the multi-disciplinary team (MDT) from a BPPS perspective to avoid diagnostic overshadowing.[8]

5.7 Diagnostic overshadowing is more likely to occur in people where communication may be problematic, such as those with dementia, learning disability or a mental health problem. In circumstances such as these, vital warning signs of a medical emergency or disease may be overlooked and an accurate and timely diagnosis delayed; often the patient is subsequently stigmatised as exhibiting 'challenging behaviour'. [9] For example, psychotropic drugs with anticholinergic side effects can result in a change in bowel movements, such as constipation, which, if overlooked, can cause serious complications for patients including pain, nausea and urinary retention. More severe bowel complications include Clozapine-induced paralytic ileus, or even ruptured bowels. [10] Consequently, a system for monitoring patients' bowel movements should be developed.

5.8 Patients on Manannan Court appeared to have limited access to independent advocates, which is a right under the Isle of Man Mental Health Act 1998. This needs urgently addressing.

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[6] See, e.g. NHS England, *'Improving physical healthcare for people living with severe mental illness (SMI) in primary care'*, NHS England (2018).
[7] Louise L. Clark & Tony Clarke, 'Realising nursing: a multimodal approach to psychiatric nursing', *Journal of Psychiatric and Mental Health Nursing* 21(6) (2014), pp. 564-571
[8] ibid
[9] Alison While & Louise Clark, 'Overcoming ignorance and stigma relating to intellectual disability in health care', *Journal of Nursing Management* 18 (2009), pp. 166-172.
[10] Birmay Cam & Mehmet Zeki Tanircan, 'Clozapine-induced paralytic ileus', *Therapeutic Advances in Psychopharmacology* 4 (4) (2014), pp. 170–172.

5.9 Greater emphasis needs to be placed on the therapeutic engagement between named nurses and their patients. Therapeutic engagement and observation are a first-line clinical risk management intervention. Therefore, a monitoring system needs to be developed to ensure compliance with the minimum requirement of named nurses meeting their patients for at least an hour twice weekly, as outlined in the *Standard Operating Procedure for the Role of Named Nurse and Nursing Teams within Mental Health Inpatient Services.*

5.10 Every patient admitted to the ward should work collaboratively with his or her Named Nurse to develop an individualised 'Therapeutic Engagement Care Plan'.

5.11 There are positive outcomes to internal rotation.[11] Therefore, this could be implemented, in the first instance, for staff that have worked on the ward for long periods. Registered Nurses on the ward may also benefit from gaining experience in an acute inpatient setting off the island.

5.12 Staff reported mixed feelings about the new shift system that has been implemented on the ward. Dr Dickinson notes that the staff who have expressed discontent with the new system have been tasked with researching alternatives. The main concern raised about the new system was that the handover period between shifts was now much shorter. Consideration should be given to extending this. To promote focused and efficient communication at handovers, staff could use the Situation-Background-Assessment-Recommendation (SBAR) protocol.[12] Additionally, 'safety huddles' could be convened at predictable times (e.g. 11.00 & 15.00), in-between the main morning and evening handovers. A safety huddle is a short, multidisciplinary briefing on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm. They offer an effective opportunity to reassess patients' observation needs throughout the shift to consider reducing them as soon as the clinical need allows.

5.13 Reports of low staff morale were difficult to quantify. Some of the RNs that Dr Dickinson interviewed reported that they felt supported but not valued regarding their clinical judgments and decisions. To address this, MDT decision-making

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[11] Tommy Dickinson & Karen M. Wright, 'Stress and Burnout in Forensic Mental Health Nursing: A Review of the Literature.' *British Journal of Nursing*, 17 (2008), pp. 82-87.

[12] Paul Cornell, Mary Townsend Gervis, Lauren Yates, & James M. Vardaman, 'Impact of SBAR on Nurse Shift Reports and Staff Rounding', *Medsurg Nursing* 23 (5) (2014), pp. 334-342.

from a BPPS perspective should be promoted. 'Ward rounds' should be renamed and reframed as 'MDT Meetings'.

5.14 The Isle of Man Mental Health Commission reported that Harbour Suite is 'chronically over occupied', and that a high proportion of patients on the ward are nursed on an enhanced level of observation. To redress this, it is pertinent that a culture of positive risk taking is fostered. The MDT Meeting would be an effective forum to discuss and decide upon positive risks, whereby each discipline's clinical judgment is valued and considered. The use of a zonal engagement and observation model should also be considered, and the personality disorder pathway should be expedited.

5.15 One issue raised by some staff was the staff/patient ratios. The staffing levels on Harbour Suite, at 7 during the day and 6 at night (including 2 RNs at all times), seem adequate for the 14 patients and remain so even when occupancy increases to 16 patients ('swing area' is in use). [13] However, Dr Dickinson was informed that these levels remain the same regardless of the number of patients on enhanced observations. Given the high proportion of patients on the ward nursed on an enhanced level of observation, this is potentially problematic. In Dr Dickinson's opinion, the current staffing levels could absorb only 2 patients on constant observation. Therefore, he recommends that for any additional patients placed on this level of observation, an additional member of staff should be sourced. At this juncture, it is important to note the common belief that a higher staff/patient ratio is related to fewer violent incidents. However, evidence suggests the reverse: a higher ratio has led to a higher degree of violence since increased opportunities for stressful interactions can occur resulting in increased violence. [14]

5.16 Dr Dickinson notes, from the minutes of the Isle of Man Mental Health Commission dated April 1, 2019, that Mr O'Mahonay advised that gender recognition legislation on the Isle of Man is significantly behind UK legislation. Therefore, a policy needs to be developed to support the care of trans* and gender-nonconforming patients. [15] The Mental Health Service *Policy and Procedure for the Search of Patients, their*

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[13] There is no national minimum staffing level. Therefore, Dr Dickinson has based this on acute wards in London. They will generally work on 5-5-4 with 2 RNs at any time; additional staff will be sought for constant observations. However, they are generally working with greater patient numbers - some wards have 22 patients.

[14] See, e.g. John R. Lion & William H. Reid, *Assaults in Psychiatric Facilities*, (New York, 1985); Morrison, 'The Tradition of Toughness'.

[15] Tommy Dickinson, Jess Bradley, Rachel Lyon, Lauren Walker & Amrita Mullan 'Diversity Issues within Mental Health Care', IN Wright, K.M. & McKeown, M. (Eds.) *Essentials of Mental Health Nursing*, (London, 2018).

Belongings and the Environment of Care within Adult Mental Health also needs to be updated to consider trans* and gender-nonconforming patients.

5.17 Dr Dickinson notes, from the minutes of the Isle of Man Mental Health Commission dated April 1, 2019, that concern has been raised over the availability of interpreters for patients. A robust system for obtaining interpreters needs to be developed, which ensures any interpreter is recognised as such, so that confidentially can be ensured.

5.18 It was noted that on occasions, drugs have been brought onto the ward by patients and/or their visitors. This have may been facilitated by patients' use of mobile phones. It is reassuring to note that the Mental Health Service has a policy and procedure for the search of patients, their belongings and the environment, and the *Therapeutic Engagement & Observation Policy* states, 'It may be necessary to remove or restrict the use of a patient's mobile phone and/or electronic devices, when on continuous observations. Any such decision to do so must be clearly documented in the patient's progress notes and be an action on their individual risk management plan'. Dr Dickinson also recommends placing a clearly visible statement on the ward, which outlines a zero-tolerance policy of drugs on the ward and warns that all incidences will be reported to the police.

5.19 Clinical and group supervision and/or reflective practice groups[16] should take place regularly with staff at all levels working clinically with patients. The frequency and duration of this should be adequate to ensure safe and competent care for people who use mental health services. It appears that supervision is often cancelled because of the levels of acuity on the ward. A system needs to be put in place whereby external factors do not impact the availability of supervision. Resources should be planned so that clinical and group supervision and/or reflective practice groups can be facilitated. If additional human resources need to be sought to facilitate this, then they should be obtained.

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[16] See, e.g. Kelly Fenton & Katherine Kidd, 'Reflective practice groups in mental health inpatient settings', *Mental Health Practice* 22 (3) (2019), pp. 28-33.