# Health Overview and Scrutiny Committee: 12 September 2013

## LAMP Response to Health Watch's concerns to the CQC's Inspection Report on the Bradgate Mental Health Unit August 2013

Information Included:

1. Report from Robert Houghton – IMHA Service Manager – LAMP
2. Comments/observations from Mental Health (IMHA) Advocates – LAMP
3. Comments/observations from Carer's Mental Health Advocates – LAMP

LAMP asks the following to be taken into consideration:

1. LAMP advocates want noted that they see a lot of good practice and staff trying their best, working hard at the 'grass roots' level of patient care in mental health. Some of this is highlighted in these reports.
2. LAMP believes that Practice, Policy, Partners, People, Patient involvement, Prevention and Intervention and Promotion of Recovery all contribute to the problems identified, thus should be constituent to the solutions.
3. LAMP believes this is not just about the hospital wards but wider issues which impact on a patients journey – developing effective care pathways for this vulnerable client group.
4. LAMP wants to know how it can help and wants to lend its expertise to improve and implement change. Since the transition to clinical commissioning groups, multi agency meetings have reduced significantly. We would have welcomed the opportunity, by LPT, to have been involved, at a much earlier stage with the difficulties experienced on the Bradgate Mental Health Unit.
5.

Denise Chaney
Executive Director
09th September 2013

**<u>Care and welfare of people who use services – People should get safe and appropriate care that meets their needs and supports their rights.</u>**

I have been approached by both staff and patients about the lack of staff on the wards. This has an impact on patients in terms of their care, treatment and safety. In particular, patients commonly raise the issue that, although they have been allowed escorted leave off the ward, there are often no members of staff available to take them, which effectively means that they have no leave or that their leave is heavily restricted. This seems to be less of a problem on Watermead, as Assertive Outreach Workers can provide some escorted leave.

One member of staff on a ward told me that there is a severe shortage of both qualified and unqualified staff and that patients' care and safety has been affected. They told me that understaffed Health and Social Care Workers have been left to care for patients, as the low numbers of qualified nurses are unavailable as they are

needed to perform other tasks on the ward, leading to poor care for patients; Health and Social Care Workers then being been blamed when things have gone wrong.

Another frequent problem is the arrangement of ward rounds for patients. On most wards, patients continue not to be given times for their ward round and, therefore, finding it difficult to arrange for an advocate to attend. When patients are given a time, it is within a broad range e.g. 9am – 12noon. Our advocates have frequently arranged specific times with wards in the ward diaries, to arrive and find that the ward round has been cancelled, without informing us, or that it has already been done earlier than arranged.

**People should be protected from abuse and staff should respect their human rights**

LAMP continues to have serious concerns that some informal patients have not been made fully aware of their rights - as is required by the Code of Practice - to be able to go on leave from the ward or discharge themselves, leading to some patients mistakenly believing that they are not allowed freedom of movement. This could result in an unlawful deprivation of their liberty under Article 5 of the Human Rights Act and false imprisonment.

We have experienced a number of instances where, although patients are informal, they have been told that they are not allowed to leave the ward. Sometimes they are given no further information, other times they are told that they will have to talk to the doctor about it next time they see them, but no time for this has been given.

The locked doors on the wards should not be in place to prevent informal patients from leaving and, such patients should have the right to request them to be opened and, unless they fulfil the criteria of a holding power, to be allowed to leave. There appears to be discordance between what nurses see to be the best interests of informal patients and the latter's rights of free movement and what seems like a marked reluctance to use appropriate holding powers in circumstances where informal patients are demanding to leave the ward.

A number of LAMP advocates have witnessed instances where informal patients have been misled; ill-informed or simply told they cannot leave the ward by staff. On other occasions, we have witnessed staff refusing to open the doors, telling patients that they cannot go out until they see the doctor or merely ignoring patients' demands to leave. On some occasions when patients are told that they cannot leave the ward until they see a doctor, the staff member is unable to say when the doctor might be able to see them, or promises are made that they will be able to see the doctor in a given time-frame, but no doctor subsequently arrives. LAMP is currently assisting a client through the complaints process at Health Service Ombudsman level for a client who claims that she was unlawfully detained for a week on a ward, when staff either refused to open the door, ignored her requests for the door to be opened or placed conditions on her going e.g. seeing a doctor, which were never fulfilled.

LAMP has met with senior management at the Bradgate Unit about the issue of informal patients' rights and it was agreed that LPT would produce a leaflet for informal patients, explaining their rights, obligations and entitlement, but no leaflet has yet been circulated.

Robert Houghton – IMHA Service Manager
September 2013

**RESPONSES FROM IMHA ADVOCATES**

**Care and welfare of people who use services – People should get safe and appropriate care that meets their needs and supports their rights.**

- One client was an in-patient on the Bradgate Unit and was disabled with mobility problems and in a wheelchair. She was moved to a different ward in the night due to pressure on beds and had to sleep on the settee in the main sitting area. This was resolved the next day but she feels she did not receive appropriate care for her needs at the time. **(Respecting and involving people who use services)** the client did not feel she was treated with respect and there was no prior consultation with her about the course of action which was taken.

- An incident where IMHA was informed by a patient that bank staff had fallen asleep whilst conducting level 1a observations.

- **Good Practice** - Qualified staff listened to IMHA suggestions about providing patient in seclusion with some distraction and were supportive of this, and promised to consider in the handover period.

- Client who was suffering with depression had been advised by her Consultant Psychiatrist (Con Psy) in the ward round that she would remain an in patient whilst the effect of her meds was monitored. Due to pressure on beds she was discharged home very suddenly. The Cons Psy was not available at the time and a junior doctor made the decision and arranged follow up by Community Psychiatric Nurse. Client informed nursing and medical staff that she did not feel well enough but discharge went ahead. Client relapsed following discharge. I assisted her to make a formal complaint and arranged a resolution meeting but unfortunately client did not feel well enough to attend. Client **did not feel she was listened to or treated with respect**, and believes her proposed plan of care by Cons Psy was breached. She also feels her **welfare was not protected.**

- Patient on Thornton Ward with learning difficulties in addition to mental health condition appears to have unmet needs. Often presents in unclean clothing and appearance is generally dishevelled. During my frequent visits to the ward patient has appeared very distressed, sometimes crying uncontrollably and other times showing more aggressive behaviour due to frustration.

Generally staff seem to be desensitised to this patient's apparent distress. Staff have admitted that this is an inappropriate care setting for patient.

**People should get safe and coordinated care when they move between different services:**

- Independent Mental Health Advocacy (IMHA) had arranged for an interpreter for a client, asking qualified staff to arrange, and she entered this in the diary; however the interpreter did not arrive for the appointment. Had to use a nurse who spoke that language (client agreed to this), however nurse was not trained in interpreting, IMHA unable to fully exercise role.

- **Good Practice** One client on Ashby Ward had a very well managed transition to Exaireo, a specialist supported housing setting for people with mental health needs and drug/alcohol dependency issues.

- Some patients have commented that they believe that they are being discharged too early. They perceive that the decision to discharge has been based on a lack of beds and someone else having a greater need, rather than this being in the best interests of the patient.

- Some patients feel that they do not have enough involvement in their care plans and there have been occasions when clients have reported being discharged without a copy of their care plan.

- Some clients discharged without adequate support in place, resulting in a readmission to hospital.

- Long waiting lists for therapy services.
- Access to services in community very difficult.

**People should be protected from abuse and staff should respect their human rights:**

- Generally there is a misconception with informal patients on acute mental health wards that they are 'not allowed' to leave the ward.

- I am unsure how much time is spent communicating and reassuring patient (mental health and learning difficulties) but from observations, it would appear that his needs are being unmet currently. I also feel that his dignity is not being protected.

- **Good Practice** Recently, I had a positive experience with new Ward Matron on Thornton. I had a conversation with her regarding an informal patient who was clearly indicating that they wanted to leave the ward. In discussion with the patient, the Ward Matron was very clear about what she felt was in the patient's best interests. She did not prevent the patient from leaving the ward

and asked that the patient return to the ward in the evening. This situation was managed well and the patient was happy with the result.

- **Good Practice** Ward Matron on Ashby Ward supports and promotes patients rights to advocacy. There have been occasions when she has rescheduled ward rounds to enable an advocate to attend a ward round with a patient.

**Supporting Workers: Staff should be properly trained and supervised and have the chance to develop and improve their skills:**

- One staff nurse on Ashby ward did not know the difference between an IMHA/IMCA (Independent Mental Capacity Advocate).

**RESPONSE FROM CARER'S ADVOCATES**

- **Carers' Resource Packs** – all wards should be giving these out to carers but this is not consistently the case as several carers who have used our services say that they have not received a copy of it when the person they care for is admitted to Bradgate Unit.

- **Good Practice:** Belvoir Unit is the exception to this.

- Carer concerned when advised the best course of action was for her son to be placed on Section 2. She expressed concern about the staff at Bradgate Unit being experienced in coping with her son who has a diagnosis of autism and OCD. My client was assured there would be no problem. This turned out **not** to be the case and her son was injected with a tranquilliser and left on a mattress on the floor all night. This resulted in her soon being paralysed with fear.

- Inadequate communication about risk paused by a patient; A patient successfully absconded from Ashby ward by rushing through an entrance door as someone else was exiting, the carer felt the patient should not have been left wandering near the exit. The patient unfortunately went on to commit suicide.

- An unwell patient was admitted voluntarily on the ward for over a month and ended up being discharged without a proper diagnosis. The carer said that the psychiatrist did not tell her or her son what was wrong

- A carer was worried that her husband, who was on Beaumont ward, was told to wait until after discharge for some of his physical health issues to be attended to. Her husband had been on the ward for three months and had no definite discharge date.