MENTAL HEALTH BOARD

(GIBRALTAR)

ANNUAL INSPECTION REPORT

2019

OCEAN VIEWS MENTAL HEALTH FACILITY

COMMUNITY MENTAL HEALTH TEAM

MENTAL HEALTH BOARD

(GIBRALTAR)

Annual Report (2019)

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). It currently consists of six members, two of whom are registered medical practitioners, one a barrister, 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.

MENTAL HEALTH BOARD

5) The Mental Health Board (MHB) first met formally on the 6th June 2018, and has met monthly, on eleven occasions, as prescribed by the Mental Health Act 2016 (MHA) and served by a Secretary seconded from the Ministry of Justice.

6) With the aim of expanding its knowledge of and establishing communal relationships in the area of mental health, the MHB has so far received presentations from GibSams, Clubhouse, and

the Mental Health Project from the Department of Education. These presentations from individuals or organisations involved in mental health will continue throughout the following year.

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

8) As a first step, it welcomed MHB participation in the in-service training provided by U.K. Solicitors specialising in mental health, under Peter Edwards Law, on the 13th and 14th September 2018.

9) Members were kindly taken by Dr. D. Pariente, a MHB member, through the full range of forms obligatory under the Act, to be completed at different stages or for different requirements.

10) The MHB also participated in the Mental Health Situational Analysis organised by the Public Health Department of the GHA, through an NHS (UK) team, in March 2019.

11) MHB established contact with the authorities of H.M. Prison at Windmill Hill with a view to offering its support in the area of mental health.

12) MHB has actively intervened on behalf of two patients now undergoing more appropriate programmes. It is currently involved in advocating for patients who lack capacity through the Court of Protection, though meeting with inordinate delay due to lack of capacity assessment reports.

13) The MHB finds that the Code of Practice document, required under Section 106 of the MHA, is undergoing an update which as yet has not been finalised, making it less effective.

14) The Board currently meets at the St. Bernard's Hospital Board Room, courtesy of the hospital administration, with the inherent limitations this entails. *The statutory duties and work of the MHBs 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.

15) The MHB's first inspection, as required under Section 116(1) of the MHA, was completed by the full Board on the 26th March 2019. Its findings, observations, and recommendations are set out below together with copies of individual Members' reports as addenda.

16) The Board is grateful for the welcome, support, and assistance its members received throughout their inspection.

MENTAL HEALTH BOARD INSPECTION (2019)

GENERAL BACKGROUND:

17) *Ocean Views* held a total of 52 patients at the time of the inspection. Staffing levels were as follows: 8.5 Registered Mental Nurses (RMNs), 5 Enrolled Nurses (ENs), and 3.5 Nursing Assistants (NAs) at *Dawn Ward (Rehabilitation)*, catering for 20 patients; 13 RMNs, 7 ENs, and 4 NAs at *Horizon/Sky Ward (Acute/Intensive)*, catering for 18 patients; 7 RMNs, 4 ENs, 5.5 NAs, at *Sunshine Ward (Elderly M.I.)*, catering for 14 patients. The ARC or activity area, is staffed by 2 Occupational Therapists (OTs), 1 OT Assistant, 1 EN, and 2 NAs. It was noted 2 RMNs provide A & E liaison. We were advised 1 RMN and 8 NAs were due to commence in mid-April; with 1NA undergoing EN training and 4 ENs completing RMN training.

18) *Community Mental Health Team (CMHT)* – (Coaling Island) has 901 active patients on its List. CMHT is staffed by 3 RMNs and 6 ENs.

OBSERVATIONS AND RECOMMENDATIONS:

Direction and communication

19) Significant and increasing investment in mental health may be evidenced through the OV and MHRT facilities but while existing strategies are being developed at different levels and locations in the community, *there is an increasing and vital need to establish an overall cohesive strategy for mental health*, encompassing all its growing elements. The recent appointment of a Matron for mental health is viewed as a first step in this direction.

20) The Department of Education's Mental Health Project for Schools provides an excellent model of how the above may be pursued within existing resources given the right focus and support.

21) *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. OV patients, for example, having to attend at A&E at St. Bernard's do not appear to be given any priority.

22) Access to management is not perceived to be readily available. *Opportunities for regular feedback should be structured into daily routines* especially since there is a clear lack of administrative support staff.

Administrative and Clerical Support

***23) This lack of adequate clerical support is a matter of serious concern.* Clinical reports are often written by hand since long delays are experienced in an increasing backlog.The risk and room for error is evident as well as are avoidable delays. Consultant Psychiatrists, for example, have a very diverse workload over different locations and are expected to produce multiple letters, reports and assessments.**

24) **In a sensitive and delicate patient process that may be handled by a variety of staff, with changes often in key players, data quality, completeness and accessibility are of the essence.** ***This administrative gap needs to be addressed.***

25) In one case MHB found 254 letters dictated but yet to be typed. The long delay experienced in obtaining Capacity Reports have prevented the Court of Protection processing the appointment of Deputies in favour of two patients needing that protection. Care Plans for discharged patients are inadequately recorded, and mostly written by hand.

Pharmaceutical Cover

26) There has been no regular pharmacist attendance at OV for a considerable period and the absence of this specialism looks to continuing unless addressed with urgency. ***Pharmacy provides a crucial contribution to clinical care in mental health*** **and such absence increases the risk, inter alia, of prescribing error, with all its consequences.**

27) Pharmaceutical cover is currently provided by two nurses whose expertise would seem available more by accident than design. One of the latter is on a short-term contract with no clear prospect of extension, which also raises the question of continuity of care.

28) **The Bella Vista, Ocean Views, and Hillside facilities would seem to provide the 'critical mass' warranting the** ***availability of a permanent pharmacist presence.***

Training and Development

29) Staff interviewed were highly committed to the Service and its patients, often acting beyond the scope of their role. There is evidence, however, that ***the current complement provides little slack*** **to help cope with absences generated through a variety of circumstances. This has clear and disquieting repercussions on training and development, as well as strain on staff.**

30) Lack of clerical support also adds to this pressure on data collection and analysis.

31) 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. ***It does not appear to be structured.*** **Knowledge of the MHA and its statutory requirements appears thin.**

32) ***There is a need for an in-service period to be structured into the year,*** **for all OV nursing grades and to different degrees, to 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.**

33) 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.**

34) 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 option.***

Admission and Treatment of Patients

35) ***Specific attention is drawn to the findings detailed in Appendix B.***

36) There is a clear need for the centralising of records, their regular updating and monitoring, with the Administrative Office having knowledge and clarity of all details concerning a patient.

37) Communication between the Responsible Clinician (RC) and the wards, and both with the Administrative Office needs improvement. RCs and wards must ensure the Administrative Office is kept informed of any changes of status under the MHA, *of any treatment requiring Second Opinion, decisions not to renew detention, or discharges.*

38) Medical staff must exercise care in completing all statutory forms fully as required by the MHA and ensuring due process in all cases and all stages as required by law. Incomplete or unrevised records present an unacceptable risk in the care of patients, as well as liability in law.

39) Sections papers and Consent to Treatment Certificates inspected were found wanting in their completion and necessary vetting contrary to MHA requirement. *Valid consent requires that consent should be informed consent unencumbered by undue influence, failing which 'consent' is not legally valid.*

40) *Management is required to vet all statutory Section forms before detention is enforced. Rendering patients informal to avoid a Second Opinion Appointed Doctor (SOAD) is a serious breach of the Act.* The role and function of a SOAD, providing the second opinion as required in the detention of a patient, is clearly defined by the MHA and nursing staff should be made aware.

41) *Excellent and commendable practice was noted in the running of the Clozapine Clinic which should serve as a model for effective Lithium monitoring, whose management gave rise to some concern. Lithium monitoring should be carried out by the CMHT in accordance with the British National Formulary.*

42) A Lithium Audit should be carried out in order to monitor standards of care in a critical clinical area.

Activity and Rehabilitation

43) Staff involved in ARC activities know their patients well and have created a relaxed and caring atmosphere. The staff complement in this area is good.

44) Communication between ARC and Dawn Ward is good with daily notes on patients written directly into Ward records. Patients from other wards are also referred to ARC. Weekly meetings are held to review the week and outcomes liaised regularly with Wards and CMHT.

45) There is concern over the state of the one transport vehicle available to ARC for their patients and this should be looked at.

46) Well organised outings into the community are built into the ARC programme and are crucial to the rehabilitation process for patients. They are effective and very worthwhile.

47) Cooking sessions are arranged but constrained by budget and budget control. Greater flexibility in how the limited funding may be used is desirable as well as cost-effective.

48) Dawn Ward presents a more problematic picture. Staff needs to be deployed to accompany patients to St Bernard's Hospital or escorted leave. This reduces ward staff availability and impacts on the level of patient activity possible. Ward staff expectancy of support from an already busy ARC complement creates undue tensions.

49) Regular, programmed GP visits would avoid staff having to escort patients to the Primary Care Centre. An appropriate room and protocol at A & E for mental health emergencies would also reduce time and help match different data recording needs.

50) There is a need for an 'Activities Co-ordinator' to stimulate life and worthwhile activity in the Ward and perhaps more might be sought via external volunteers.

51) Given the communal strategy on smoking, the significant reliance on cigarettes as a seemingly 'reward' or 'activity' option is to be questioned.

52) Staff limitations have also constrained the full and proper use of the Rehabilitation Flats as an appropriate level of supervision is not readily possible. This also seriously affects supervision of the external rehabilitation flat at Kent House.

53) The recent employment of a very committed Clinical Psychologist has been very welcomed and is having a salutary effect on staff morale.

Discharge and Care programmes

54) The discharge letter currently in use offers little space for meaningful Care Plan details. An improved Care Plan letter has been designed (appxC/2) but is as yet not in use.

55) Though the filing system at CMHT has seen an improvement, *it was not easy to locate particular Care Plans and most of these consisted of a few lines on a discharge record.*

56) An improved and more detailed form, after discussion with the senior psychiatrist, is offered and its adoption encouraged (appx C/3)

57) Patient perspective of care after discharge offered a mixed reaction and would suggest a follow-up based on a wider audience.

58)* Discharge correspondence and records are sent to CMHT and GPs at PCC, but *the latter are not identified by name nor is there a check whether the information has entered the PCC digital record. This gap in the system should be addressed.

***59)* Discharged patients are given: an appointment date with Psychiatrist at CMHT; 14 days supply of medication; and a list of contact telephone numbers for mental health support services. *Regard should be had that these are, by definition, vulnerable adults with more limited capacity*, and their Care Programme should include home contact by relevant support services to ensure compliance, especially with medication.**

***60)* *There is concern as to the appointment of part-time counsellors who are not accredited by a UK regulatory body* and offer very limited experience in what is a very demanding and sensitive role.**

***61)* There is an increasing need for GHA to promote a platform where all agencies and groups, official and voluntary, fully or partly involved in mental health, may come together to reflect on the Mental Health Service, promote good practice and spear-head development.**

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APPENDIX A

GIBRALTAR GAZETTE

EXTRAORDINARY

PUBLISHED BY AUTHORITY

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Government Notice No. 674

MENTAL HEALTH ACT 2016

NOTICE OF APPOINTMENT OF
MEMBERS OF MENTAL HEALTH BOARD

It is notified for general information that, in exercise of his powers under section 113(3) of the Mental Health Act 2016, the Minister with responsibility for Health has appointed the following persons as members of the Mental Health Board–

Mr Julio Alcantara (Chairman)
Mr George Parody
Mr Kenneth Navas
Dr Rene Beguelin
Dr David Pariente
Ms Emily Adamberry Olivero

The members are appointed for a renewable term of 3 years in accordance with section 113(4).
Dated: 23rd April 2018.

Government Notice No. 675

MENTAL HEALTH ACT 2016

NOTICE OF APPOINTMENT OF
REGISTERED MEDICAL PRACTIONER FOR PURPOSES OF PART 3

It is notified for general information that, in exercise of his powers under section 45(2)(a) of the Mental Health Act 2016, the Minister with responsibility for Health has appointed Dr David Pariente as the registered medical practitioner for the purposes of Part 3 of the Act
Dated: 23rd April 2018.

APPENDIX B

FIRST INSPECTION OF MENTAL HEALTH SERVICES - 26th MARCH 2019

COMMUNITY MENTAL HEALTH CENTRE, COALING ISLAND

The Mental Health Board members [KN & DP] met with two of the CMHT senior staff and, after a general briefing on the service, were shown round.

The medical records storage area was inspected and found to be clean, airy and well organised, with files easy to locate, an achievement considering the limited clerical support available..

It is a matter of concern that psychiatric staff may have to hand write clinical reports to General Practitioners and that they have no local secretarial support; typing of clinical reports depends on a PC dictation system (Big Hand), but there are long delays before the typed reports are returned to the medical staff and this delay diminishes the clinical usefulness of these reports.

Adequate clinical communication with General Practitioners is crucial for the safe and effective delivery of care and is inevitably limited if it depends on brief hand written reports, not always legible; or if the delay in the report being received outlives its 'sell-by' date.

Fuller reports allows the General Practitioner to assume a greater role in clinical care and even take over the continuing clinical care, relieving pressure and demand on the mental health services.

Recommendation: The provision of adequate secretarial and administrative support is most likely to prove cost effective by improving standards and safety of clinical care.

The inspection then addressed two specific areas, the management of patients on clozapine and on lithium, the most recent major advances in Psychiatry effective in controlling severe and enduring mental illness. However, both drugs have very narrow margins of safety and must be closely monitored to avoid causing serious side-effects, and even death.

CLOZAPINE CLINIC: We were impressed by the well-run clinic and the effective way in which all patients on clozapine are monitored, the essential blood tests managed and recorded, and the clinical information imparted to the respective Responsible Clinician.

Recommendation: The clinic is an example of good multidisciplinary practice and effective clinical care. It should be commended.

LITHIUM: The management of patients on lithium is a matter of some concern. The medical records reviewed show that the treating psychiatrist will leave it to the General Practitioner to arrange the lithium serum levels and other required blood tests essential to monitor the potential serious side effects of this drug (e.g. damage to heart, kidneys, parathyroids and thyroid). This practice requires that the patient remembers to make an appointment with a GP some time later to be given an appointment for blood tests and then, weeks later, attend the CMHT for the blood tests to be reviewed. Such a course is fraught with pitfalls, and may result in abnormalities in the results remaining unseen and un-addressed longer than the narrow margin of safety permits, with potentially serious, even fatal, consequences. Equally if the serum lithium level is below the therapeutic range, clinical control may be lost, increasing risk and resulting in additional demands on the service; if it is above the therapeutic range, then the additional burden may fall on medical and emergency services.

Recommendation: The Clozapine Clinic good practice is a model for effective lithium monitoring. Lithium monitoring should be carried out by the CMHT, the blood tests arranged at the time of the consultation and a system to ensure compliance and that results are reviewed immediately they are available. The **British National Formulary** recommendations must be followed: " ... Samples should be taken 12 hours after the dose ... Routine serum-lithium monitoring should be performed weekly after initiation and after each dose change until concentrations are stable, then every 3 months thereafter ... Monitor body-weight or BMI, serum electrolytes, eGFR, and thyroid function every 6 months ... ".

A Lithium Audit carried out over a year ago by Dr Alan Lillywhite needs to be repeated to monitor standards of care in this most important clinical area, a major source of litigation in the U.K.

OCEAN VIEWS MENTAL HEALTH FACILITY

CONSENT TO TREATMENT CERTIFICATES

We reviewed the consent to treatment certificates for the four recent discharges.

1. A T2 completed by the Responsible Clinician did not set British National Formulary limits for doses, as is required.
2. A T2 completed by the RC stated that the patient lacked capacity, yet a SOAD opinion was not requested and treatment in breach of the MHA2-016 was proceeded with. Had the Consent to Treatment Certificate forms been vetted, as is required, this should have been picked up and rectified.
3. The SOAD left out the name of the patient in a T3, but this was picked up by the Administration Mental Health Act Office and the name added later.
4. One T3 did not have the SOADs reasons on a second T3 on the same patient.

The Consent to Treatment Certificates for the patients in Sky, Horizon and Sunshine Wards were reviewed.

There were examples of unauthorised additions of 'as required' medication not authorised in the T3 Consent to Treatment Certificate, though adequate 'as required' medication had already been prescribed and authorised and the unauthorised prescription was never used. In one case clozapine was authorised by the RC and prescribed under the emergency procedures under MHA 2016 s55/56 (5)(b) "immediately necessary ... " presumably to circumvent a SOAD opinion, as clozapine does not act "immediately" and could not be started until the required blood tests still then pending were carried out.

A patient with chronic psychosis and a dual diagnosis, previously under a T3 Consent to Treatment Certificate, was deemed to have consented to treatment, when he made it plain that he only consented in order to achieve leave and would discontinue treatment given the opportunity, raising the issue that consent was not valid and the T2 illegal.

One patient on s3 had no Consent to Treatment Certificate having been detained more than three months; we were told that she had been regraded informal, but we could find not documentary evidence of this.

Several T2 Consent to Treatment Forms did not state that the medicines were to be prescribed within BNF limits, giving latitude for the RC to exceed these safe limits, without any clinical justification being recorded, as is required.

A substantial number of T2 Consent to Treatment Forms remained in use despite the RC having changed. A change in RC requires a new T2 to be completed by the new RC, even though existing T3 remain valid and a new SOAD opinion is not required if there is a change in RC.

A significant number of patients receive surprising number of drugs, some with the same action, e.g. one 85 old detained under s3 was receiving two different sleeping preparations!

SECTION CERTIFICATES

We reviewed a selection of section papers, mostly s2 and s3, one s4 and one s5. We found that compliance with the requirements is adequate, with mostly relative minor, but yet significant issues which, nevertheless, may put in question the legal validity of the forms.

The most common error is GPs not crossing out that they are s12 Approved Doctors under the Act, amounting to a false claim.

We found it difficult to retrieve section papers from the medical records. It would help if copies of the section papers were printed in a dedicated coloured paper so as to make them easily retrievable from the medical records.

We are concerned that there is poor communication between the RCs and the wards, on one side, and the Administrative Office on the other. It is crucial that the Administrative Office should be able to centralise and monitor all the MHA 2016 events, and keep the data base updated. The office needs to be notified of discharges from section and when it is not proposed to renew detention. The medical records had discharge certificates of which the Administrative Office had no knowledge.

SERIOUS BREACHES OF H.L. v the UNITED KINGDOM – THE BOURNEWOOD JUDGEMENT

The European Court of Human Rights rules that the informal detention of compliant but incapacitated patients is an unlawful deprivation of liberty.

Clearly, such informal detention deprives the detained person of the protection provided by the Mental Health Act 2016, including access to the Mental Health Review Tribunal and a SOAD opinion; and the protection offered by SROLS under the Enduring Powers of Attorney and Capacity Act 2018.

It is with deep concern that we record that three of the patients interviewed in Sunshine Ward were held 'informally', without the protection of the MHA 2016 or a SOAD opinion; some were receiving a surprising number of medicines. All three lacked capacity, and two were wheel-chair bound, but indicated that they wished to leave and return home.

One T2 form inspected failed to meet the required criteria. We found it difficult to establish whether that one patient required a Consent to Treatment Certificate, as s3 detention was interrupted in order for a trial transfer to Mount Alvernia. The s3 was renewed on the return to OV, following the failed trial. The transfer informally without SROLs raises legal issues. It is unclear why trial leave at Mount Alvernia was could not be under s16 leave, MHA 2016. The Care Agency should have relied on SROLS if they refused to accept trial transfer under s16 leave. A certificate rendering the patient informal was filed in the medical records, but the Administrative Office had no knowledge of it

It is concerning that nursing staff had been told that a SOAD opinion is only required when a patient has been detained for three months under s3. The MHA 2016 leaves no doubt that a SOAD opinion should be requested before the patient has been detained for three months, even if detention started under s2.

Care in the completion of section papers by some RCs needs improving to avoid misunderstanding and ensuring clarity. In several forms all the various alternatives were crossed out, suggesting that the statutory requirements and criteria were not met; we assume that ticks were meant, instead of crossing out the alternatives.

CLEANLINESS OF LIVING AREAS

We were concerned that the floor of the area between the dormitory corridor, the day room and the long gallery was dirty in Sunshine Ward, and with bits of rubbish strewn.

RECOMMENDATIONS:

1. All MHA 2016 certificates must be vetted by the MHS Manager, as the Nominated Inspector under the MHA 2016, as required, and approval shown by a stamp and signatures.
2. AMHP should be issued with a List of Approved Doctors updated regularly) so as to ensure that no medical practitioner makes the false claim to be s12 Approved under then MHA 2017, however unintentional and innocent the claim may be.
3. RCs and wards must ensure that the Administrative MHA Office is kept informed of changes of status under the MHA 2016, of any treatment requiring a SOAD opinion, and of the decision not to renew detention; discharges from detention forms must be copied to the Administrative Office.
4. The assessment of capacity to consent must be recorded in the medical records, preferably at a ward round or with another professional present.
5. Valid consent requires that consent should be informed consent unencumbered by undue influence, failing which such 'consent' is not legally valid.
6. It is crucial that all staff should understand and accept that all those concerned with medication are equally responsible in law under the MHA 2016. The doctor is responsible for prescribing, the pharmacy for dispensing and the nursing staff for administering only medication authorised by the Consent to Treatment Certificate and each is liable for any breaches.
7. Medical staff must exercise care in completing all statutory forms accurately is required.
8. A change in RC requires a new T2 to be completed by the new RC, but T3 remain valid.
9. Discharges from section, and copies of discharge certificates, and decisions not to renew must be shared with the Administrative MHA Office.
10. The continuous Audit of Consent to Treatment needs to be repeated, preferably now by an outside source. It was started when the Act as implemented and repeated regularly since, but continues to detect serious failures to comply with the requirements of the MHA 2016.
11. The Code of Practice needs to be finalised and circulated. It is an indispensable tool.
12. A Lithium Audit carried out over a year ago by Dr Alan Lillywhite needs to be repeated to monitor standards of care in this most important clinical area, a major source of litigation in the U.K.
13. A Clinical Pharmacist is an essential addition to OVMHF to review medication, rationalise the excessive number of prescriptions many patients receive, address drug interactions, improve standards and safety and act as a valued consultee for SOADs

(Dr.David Pariente Mr. Kenneth Navas)

Appendix C

Inspection of Ocean Views 26th March 2019

Areas Inspected: ARC (Activity & Rehabilitation Centre) and Dawn Ward

When I have visited the hospital before I have always found patients wandering about the wards somewhat listlessly and really busy doing nothing. I have talked to some of them and the answer I invariably get is that there is "...nothing to do...", that they are "bored."

As a result of these short interchanges I have made a point of having a closer look at the facilities that the hospital has to offer (ARC) and to see for myself if there is any truth in the above statement.

Since Dawn Ward is the hospital's Rehabilitation ward, I decided also to look at the way the staff copes with patient boredom and the activities that take place at ward level.

The fact that I have spent a few hours at this task necessarily means that I can only take a snap shot of what occurs and it would be improper of me to state that I have all the solutions. However, although there may be areas that have escaped my notice, it is also significant that a view from a different perspective does sometimes bring up some issues that are of common concern.

From the beginning the whole staff at the hospital were more than willing to contribute and clearly felt passionate about their jobs and were justifiably proud of where they were, as opposed to where they had come from (KGV).

The Activity and Rehabilitation Centre (ARC)

My observations are based on interviews with all the Saff at ARC:

Senior 1 Occupational Therapist
Senior 11 Occupational Therapist
Occupational Therapist Technician
Enrolled Nurse
2 Nursing Assistants

As there were no group sessions on the 26th I also visited the ARC the next day to observe a cooking session. Similarly I arranged a meeting with the Senior Occupational Therapist on the 28th as she had been involved in a session at St. Bernard's Hospital on the day of the inspection

Without exception they were all very forthcoming, welcoming and willing to share their experiences and good practices. I also found that they knew their patients well and demonstrated a genuine care for them. The atmosphere at all times was relaxed and the patients seemed to know the routine. There was good humour, but clearly a gentle reminder was enough to encourage patients to keep on task.

Patients also seemed to enjoy the activities and therefore "felt" and "looked" more at ease. I attribute this to the fact that they had something productive to do. I took the liberty of taking pictures of the Art & Craft materials they produced as well as some of the activities they were engaged in (See attached photographs in Supporting material). There were various tables of jigsaws and word search books as well as two desktop computers for patients to access the internet. I saw no one using them during my time there, but I was informed that when one did, they were supervised by a member of staff. There was an aviary session once a week as well cooking and hopefully they were trying to start a garden project.

I found there to be good communication between ARC and Dawn Ward and general day to day notes on patients are written directly into the ward notes. Patients from other wards are also seen by ARC, when the wards refer them. As can be seen from the 2018 attendance register all wards use the ARC including patients already in the community. The ARC facilities can also be used by other wards, if it is not being used for ARC sessions.

Patients are assessed and dealt with appropriately, either individually and in groups. Meetings are held daily to briefly review the caseload, highlight any changes in risk or clinical state, organize work, allocate tasks to team members and offer support. (I did not witness this meeting, but I am told this happens daily)

Likewise Weekly meetings are held to review what has happened during the week and they liaise regularly with the wards as well as CMHT.

I am led to believe that there is Clinical supervision and that all ARC staff have access to regular supervision and annual appraisal.

I asked about staffing levels and was genuinely surprised when I got a positive reply. Apparently prior to 2016, there had been staff shortages, but by 2017 the full complement was reached. Of course, who would not want an extra pair of hands, but they seemed more worried about the fact that they did not have an adequate bus. They did show me the bus and clearly they have a point, especially when I see all the pristine Bella Vista buses parked next door!

ARC has a budget to organize various activities and events during the year. Planning and staffing with the appropriate risk assessments are carried out prior to a visit. What seems a simple "outing" involves a lot more. I found this part of their work to be crucial, to the rehabilitation process as it provides patients with the necessary social skills, confidence and motivation to perform what we consider to be "normal" everyday activities. Although, of course, I did not participate in an outing, the feedback I received from all the staff and some of the patients point to a very worthwhile activity, which I believe should be further encouraged and funded. This does make a difference and it does not cost the earth!

When I talked to the staff during the cooking session, they told me that they sometimes felt that they had to tailor their sessions according to the budget, rather than choice from the patients themselves. What they do is ask everyone what they want to eat from a particular country and then the ingredients are bought. It is clear here that the budget needs to be flexible. Later when I talked to the Senior Occupational Therapist, she did inform me that she had a budget for such activities that she had to stick to. Considering the small sum of money involved, I don't think that it would too difficult to give them a greater level of freedom. When I talked to some patients after the meal they related some wonderful meal they had had in the past with gusto!

When I asked about their role on the wards, issues started to surface. It seemed to them that the ward expected them to take the lead all the time in organizing activities for patients and they believed that they could not do everything themselves. They realized that the ward had constraints, but that something had to be done about it as it was in the interests of patients for them to be fully engaged whenever possible.

It is very interesting that this same point was raised by the ward personnel, who acknowledged that this was a concern, but did state that staffing and varying shift patterns often got in the way.

One member of Dawn staff suggested that there should be some form of "Activities Coordinator" that would liaise with ARC and ensure that some activities would take place. I thought this was a particularly good idea and goes hand in hand with the idea of ARC staff doing some in house training for the ward nurses.

After observing the cooking group session I was surprised at the queue of patients wanting their cigarettes before they left. It gave me the impression that patient smoking plays a large part in the reward system at this hospital. This was reiterated when I visited Dawn Ward, where there was a queue forming at the sister's office ten minutes before the appointed time.

I don't wish to presume to have the solution to this dilemma, but as it forms a very large part of patients' lives, then I believe it needs to be addressed. I was informed by some of

the staff that some NHS hospitals have made inroads into weaning patients off cigarettes by the use of patches and specialist trained nurses. I do not know if it has been successful, but it seems to me that it should be investigated.

I also believe that before the smoking ban, staff who smoked, would accompany patients to the garden, but now they are seen regularly by the roadside, puffing away.
I travel that road quite a number of times a day and it does not give a good impression. As I said before I do not have the answer, but it is a concern that perhaps requires re-visiting.

Dawn Ward

I met with four members of staff at Dawn Ward. They were all friendly, forthcoming and generous with their time. They demonstrated a genuine care for their patients and wanted to make their time there less stressful. I felt that they welcomed the opportunity to have a say to someone impartial.

There are two issues which relate to Dawn Ward, which I have discussed before. That is the question of smoking and activities within the ward. A large part of our discussion centred on these two points and the conclusions have been made previously, so I am not going to repeat them. Suffice to say that both ARC and Dawn Ward identified them as concerns independently.

Dawn Ward houses 21 patients, with a staff of 5. Because of the nature of the facility, there are times when staff are deployed to accompany patients to St Bernard's or take them out on escorted leave. This necessarily reduces staff numbers and has a bearing on what they can do with the patients. While I was there a member of staff escorting a patient to hospital was away for a good couple of hours.

A solution might be to have a GP call on the hospital certain days of the week. This would free a member of staff and at the same time ensure that all patients' medical needs are being attended to. Again I have to bring up the example of Bellavista, where a GP regularly attends the medical needs of dementia patients.

Staffing and short notice shift work was the main concern expressed by the staff. They were conscious that activities needed to be carried out by themselves, but the above did not allow them the kind of flexibility conducive for this to take place. Regardless of this they would welcome some form of "Activities Coordinator" to help organize and galvanize the ward. It was very evident when I toured the ward that apart from mindless watching of TV and queuing up for cigarettes, there was little to occupy them.
The lack of staff also impacted on their ability to deal with the challenges of the Rehabilitation Flats, which at the moment are little more than extra beds for the wards. In order for the flats to be fully functional there needs to be a greater level of supervision and

support so that patients can carry out tasks independently. Going in regularly does not really address the situation and simply means that the ward has one less member of staff.

Similarly they have responsibility for a flat at Kent House in Scud Hill, so it means that an extra member of staff needs to be deployed to supervise. As this is not always possible, the patient needs to be brought in to Dawn Ward for review. Clearly not something conducive to the concept of rehabilitation.

On a practical note, the staff commented that on occasions they had received parking tickets for parking in a restricted zone. Surely there should be a permit that Government can extend to anyone visiting Kent House? Simple actions like these do not require a degree in rocket science, but it can alleviate a totally unintentional consequence of the Zonal Parking Scheme.

Another concern expressed by the staff had to do with escorted leave and funding for the same. At times nurses escorting patients have had to pay for coffees etc. as the budget of £50 was either not available or had not been released. On that same day I went in, the funding had been released and I hope it is something which will be easily available in the future. Again, not a huge problem, but one which niggles those members of staff who take patients out on escorted leave.

Meeting with newly appointed Consultant Psychiatrist

In the middle of my interviews at Dawn Ward I met a newly appointed Consultant Psychiatrist.

I was impressed that he had already spoken to the Police, an agency, which is in the front line, but is often forgotten when we talk about Mental Health. Very often they are the first respondent and it is crucial that they are able to handle the situation correctly and know what support services they can count on to assist the patient.

Likewise he has already met with the Head of A & E with a view of overhauling the present protocol, a fundamental linchpin in dealing with mental health emergencies. He also spoke about the role of the newly appointed Mental Liaison Nurses. I just hope that they manage to allocate a properly equipped room, rather than the inadequate family room that is presently used.

Interestingly his contract stipulates that he has to live in Gibraltar and needs to respond to a crisis within the hour, which is a great improvement to the situation we have had in the past.

These developments are crucial when dealing with mental health emergencies at the coalface, however we need to see how it works in practice before we can evaluate its effectiveness.

Recommendations

- Ongoing visits need to be made to top Mental Health facilities in the UK to observe good practice.
- These should be followed by INSET training for all ward staff using a cascade model.
- As a result, an "Activities Coordinator" should be nominated in every ward to ensure that there is good liaison between the wards and the ARC and that activities are carried out regularly.
- Extra staffing needs to be deployed to Dawn Ward to deal effectively with the two rehabilitation flats and Kent House.
- There should be greater budgetary flexibility when dealing with rehabilitation activities
- A GP should visit the hospital regularly to cater for patients' medical needs.
- The acquisition of a new bus similar to Bella Vista's should be considered.
- The Smoking policy needs to be re-visited.
- The new A & E protocol needs to be established and made public.
- A room, other than the family room, be made available to mental health emergencies at A & E.
- Notwithstanding the merits of local inspections, future audits should be carried out professionally by the same body which audits UK hospitals. The Care Quality Commission (Independent regulator of Health and Social Care in England) has the professional expertise to carry a full inspection. These they do in force and over a longer period of time.

(Mr. George Parody)

APPENDIX D

Report on Mental Health Board Inspection Visit on 26th March 2019 by Dr Rene Beguelin and Emily Adamberry Olivero

Aims and Objectives

These were to find out what after care is provided to patients once they are discharged into the community and what follow-up there is.

Introduction

In order to ascertain the care given to patients once they were discharged into the community we needed to inform ourselves on how the system worked and how we could find out where to find the relevant care plans. The interim discharge letter being used (Appendix 1) does not offer much space for a meaningful care plan. An improved discharge letter has been designed but apparently it is not yet being used. (Appendix 2)

The filing system has been improved with dividers being used making it easier to locate the care plans.

However when checking a random selection of files at the store in Coaling Island it was not easy to locate the Care plans. Most care plans were included as a few lines on a discharge record. It was not easy either to ascertain which patients were receiving care from CMHT and what care plan were currently in place.

From discussions with the senior psychiatrist an ideal care plan form has been designed (Appendix 3) which encompasses the different areas that should be considered in order to provide a meaningful care plan. It also includes the relevant guidelines. In its present form (as a computer document) it can be used and expanded according to each patient's needs with the following sections:-

- Mental Health
- Physical Health
- Addictions
- Risk Assessment
    - Risk to self
    - Risk to others
    - Risk of Neglect
    - Engagement with Care Plan
    - Risk of Relapse
- Specific Interventions (when appropriate)
- Information about people participating in the Care Plan and Review schedule

This would avoid the need of having to use only the information provided in a limited space on the current forms used. Sadly this has not been implemented yet.

PATIENTS PERSPECTIVE

We were able to interview 2 patients on Horizon Ward

Both agreed that they were being well looked after in hospital with one commenting that 'they do more than enough'. As regards medical treatment one was not content but was pleased to have been asked for his opinion.

As regards aftercare one said that he received his depot injection at CMHT and was also able to drop in for a coffee now and then.

The other stated that she did not intend to use Coaling Island services after this first admission as she had phoned once and did not like that all she had been told was to contact her GP and the phone was hung up. She also went on to say that psychiatry should be less judgmental.

OCEAN VIEWS

Organization of files

It was encouraging to find that the organization of files seems to be improving with dividers being introduced to separate files into different categories.

This had only been applied to the most recent files and examples were found on the first ward that we visited which was the Acute Horizon Ward:

- Admission Assessment
- Psychiatric Notes
- Legal/Section Papers
- Investigation Results
- Daily Nursing Notes
- Observations
- Care Plans
- Correspondence
- M.D.T. (Multidisciplinary Team)
- Meds (Medications)

Interim Discharge Letter

Care Plan is usually embedded in this document on or after the last line "follow-up arrangement" and "OPD appointment" at CMHT.

And this could be found in the Correspondence tab from previous admissions. This is sent primarily to the CMHT + AMHP and the GP at the PCC although this Doctor is not usually identifiable. This system of communication needs improvement (e.g. an appropriate e-mail address at the PCC which would ensure the information enters the GP EMIS digital practice programme.)

When a patient is admitted his file is accessed from Coaling Island Records store within 24 hours. This is also available immediately by the AMHP out of hours in an emergency.

The file returns to Coaling Island within one week after summaries written and often e-mailed.

When a patient is discharged he is given

- an appointment date with the psychiatrist at Coaling island
- 14 day's supply of medications
- A list of contact telephone numbers for mental health support services

Care Plan Record Sheet (blue paper)

The Section B Care Plan Record sheet is part of the New Tidal Assessment Model September 2009 (Appendix 4). These could be as many as the modalities of care that were planned and carried out *while the patient was admitted* and could then continue into the community setting as separate Care Plan Record Sheets:

- Nursing
- OT
- Diabetes
- Foot Care
- Leave
- Meds
- Psychologist
- Employment
- Education
- Benefits
- Shunt
- Chiropody
- Debt Management
- Falls
- Mobility
- Dental Care
- Sight
- Hearing
- Nutrition
- Medical Care

PSYCHOLOGISTS AND COUNSELLORS

In patient Clinical Psychology

This post was vacant for a whole year before the appointment of the current Psychologist.

Counsellors In Primary Care Centre

We were informed that the two newly appointed part time counsellors were not UK accredited and insufficiently experienced and therefore not suitable to the demanding nature of their position. (See Appendix 5, copies of e-mail correspondence).

Psychological Assessments Prior To Bariatric Surgery

In addition to the workload of patients with psychiatric illness who need psychological intervention , the psychologists at CMHT have also taken on extra work loads from individuals considering Bariatric Surgery. (Appendix 6)

At present there are 42 patients on the waiting list and more are added weekly. Concern was raised about the inability to hand over the complex workload from the outgoing Head of Psychology (who is currently doing this work) to any successor as the logical successor is currently employed on a service level agreement which is due for renewal in April. (See copes of e-mail correspondence).

Coaling Island Overview

We were only able to speak to onepatient

- 2 Registered Mental Nurses or RMNs (previously 4) + 5 Support Workers, all Enrolled Nurses + 1 RMN on long term sick leave + RMN vacant post
- 496 Patients
- 150 Patients requiring extra support
- Referral sources include also St Bernard's Hospital, GPs and A+E
- Mondays allocation meetings
- Continuity of care by the same medical professional is not good
- One full time Consultant on a three year contract,
- Three consultants recovering from long term work related sick leave still working part time
- Rapid turnover of locum short term consultant cover
- 21 outpatient clinics per week
- Only one part time Clerk/Receptionist for the whole of CMHT service
- Recent choice of individuals appointed as Matron and AMHPs do not have the confidence of CMHT senior staff
- Open 8am to 5pm Monday to Friday
- In addition to clinics at Coaling Island patients are seen during home visits, at social services, at cafes, prison, at Ocean Views and St Bernard's Hospital
- When a patient does not attend on 3 consecutive scheduled appointments they are discharged from Coaling island

Electronic Patient Records

- PCC EMIS GP consultation record with all investigations and correspondence can be accessed on a read only basis
- Electronic prescriptions and GHA Pharmacopoeia are available online and recorded on EMIS

Conclusion & Recommendations

Care Plans

The only care plans that we could locate in some files only, consisted of brief comments on the limited space available in the discharge letter. We were able to see a holistic ongoing care plan which in its virtual form can be added to as the patient progresses through all aspects of their care needs. This would be an enormous improvement and we recommend its implementation.

Files

Recent files at Ocean Views had the documents organized within dividers and made the files easier to use. However this was not seen in all files and seems to be a recent improvement being applied to in patients. The majority of files are kept in a store at Coaling Island until required and on inspection we found that most files did not have dividers and were therefore not easy to follow.

Administration support

We were informed that the only clerical support was one part time admin clerk at Coaling Island. Clearly there is a great need for more clerical or typing support given that the Consultant Psychiatrist had 254 letters which he had dictated and still needed to be typed and sent. Moreover in a typical clinic of 18 patients an average of 6 patients do not turn up. With additional admin support and an effective reminder system for appointments a more efficient service could be run.

Support for Consultant Psychiatrists

Consultant Psychiatrists have a very diverse workload over different locations and are expected to produce multiple letters, reports and assessments. However they hardly have any support. Consultant Psychiatrists would benefit from junior medical staff (e.g Pre-Registration doctors or trainee Psychiatry Registrars) to help deal with routine medical tasks and they also require a typist or admin assistant to help with the paperwork and ensuring that the reports are forwarded in a suitable time frame to the Primary Care Centre.

Psychologists and Counsellors

There is now a Clinical Psychologist based at Ocean Views which is a welcome improvement even though this post took a whole year to be filled.

Given the complexity of many patients' needs for psychological intervention, it is essential that there is sufficient staff of the right calibre to meet those needs. During our visit we met the Head of Psychology who was unhappy with the choice of counsellors recently employed at the Primary Care Centre as they lacked accreditation and sufficient experience.

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Tel. +350 20078807 Fax: +350 20040045

Community Mental Health Team
Coaling Island
Tel. +350 20042307 Fax: +350 20041658

CARE PLAN

ADMINISTRATIVE INFORMATION:

Name: DOB: GHA No:
Address:
Responsible Consultant: GP Group:
Named Nurse:

Diagnosis: ICD-10:

MENTAL HEALTH:

Degree of Disability: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

PHYSICAL HEALTH:

Degree of Disability: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

ADDICTIONS:

Degree of Disability: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

SOCIAL LIFE AND NEEDS (Accomodation, Work, Finances, Self-care, Family, Cultural, Education, Spiritual)

Degree of Disability: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

RISK ASSESSMENT:

RISKS TO SELF

Degree of Risk: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

RISKS TO OTHERS

Degree of Risk: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

RISKS OF NEGLECT

Degree of Risk: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

ENGAGEMENT WITH CARE PLAN

Degree of Engagement: Poor - Moderate - Good

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

RISK OF RELAPSE

Degree of Risk: Low - Moderate - High

Targets/Areas of Attention	Interventions Required	By Whom	Target Date

- **SPECIFIC INTERVENTIONS** (When Appropriate)

MHA Status: Observation Level: Leaves: Residence/Placement:
Referrals: (end date) Comments/Information:

INFORMATION ABOUT PEOPLE PARTICIPATING IN THE CARE PLAN AND REVIEW SCHEDULE

Named Nurse: (Name, Signature)	
Consultant: (Name, Signature)	
Other participants: (Name, Position, Signature)	
Patient: (Name, Signature)	Care plan discussed with patient on:
Date of next review:	

CARE PLAN FOR MENTAL HEALT SERVICE, GUIDANCES

A care plan is an essential part of the care provided for every patient within any health service. Especially within the Mental Health Services it is particularly important to have a robust care plan where the needs of our patients and the interventions required in respect to those needs are clearly identified.

The model of care plan presented in Appendix 1 includes several sections:

1) Administrative information about the patient.
2) Assessment of the needs
3) Risk assessment
4) Specific interventions
5) Information about relevant people participating in the care plan and review schedule.

1) Administrative information section.
Includes information about the patient including: name, address, telephone number, date of birth, GHA number, GP group, responsible consultant and named nurse.

2) Assessment of need section.
Includes several headings:

2.1) Mental health
2.2) Physical health
2.3) Addictions
2.3) Social life and social needs.
Information in this section will cover aspects related to accommodation, work, finances, self-care, cultural, education and spiritual needs.

Within each heading of this section there is a basic scale rating from low, moderate or severe the degree of. This scale should, whenever possible, be completed considering the patient's point of view. This will facilitate the participation of the patient in his/her care planning and will also evaluate the level of concordance between patient and staff in the perception of the patient´s needs.

In the following area there are boxes to concisely describe the targets or areas of attention. Those boxes should be filled with a concise description of the intervention required, indicating who should be coordinating the intervention and the target date for completion or otherwise if the intervention is an on-going process. Information here should be introduced in bullet type format for clarity and easier identification of the needs and interventions.

Example:

PHYSICAL HEALTH:
Degree of Disability: Low - Moderate - Severe

Targets/Areas of Attention	Interventions Required	By Whom	Target Date
>Hypertension	>BP checks weekly	> Nurses	> During admission

3) Risk assessment section.
Included several headings:

3.1) Risk to self
3.2) Risk to others
3.3) Risk of neglect
3.4) Engagement with the care plan
3.5) Risk of relapse

Within each section there is also a brief scale rating from low, moderate or severe the level of risk to self, others neglect and relapse and poo, moderate or good the level of engagement with the care plan. This scale should be completed, whenever possible, by the patient and also by the staff, and will also evaluate the level of concordance between patient and staff perception of the risks.

In the following area there are boxes to concisely describe the targets or areas of attention, followed by concise description of the intervention required, who should be coordinating the intervention and the target date. Information here should be introduced in bullet type format for clarity and easier identification of the needs and interventions.

Example:

ENGAGEMENT WITH CARE PLAN

- Degree of Engagement: Poor - Moderate - Good

Targets/Areas of Attention	Interventions Required	By Whom	Target Date
>Poor concordance with medication	>Meds dispensed in blister pack	>Dr: prescription. Pharmacy: dispensing. Nurses: supervision while inpatient. Partner: supervision while in community	> Admission period/community leaves

4) Specific interventions
This section includes several headings:

4.1) MHA status
4.2) Observation level
4.3) Leaves
4.4) Residence/Placement
4.5) Referrals

4.6) Comments/Information

This section is to be used mainly for inpatients, although it could be also useful for patients on CTO or residents in supported accommodations.

The headings: "Observation Level" and "Leaves" will generally be filled with an entry like: "as per documented in clinical notes" and " as per in section 16 form" unless other information is considered relevant, like for patients with specific arrangements like those on extended leaves, residents in hospital flat, etc.

This section also includes a heading to record referrals made to relevant agencies or departments like Care Agency, Psychologist, District Nurse, etc. and the date it was made. There is also another heading to include comments or relevant information not included in other previous sections.

5) Information about relevant people participating in the care plan and review schedule.

In this section it should be recorded the name and signature of the Named Nurse, the Consultant in charge of the patient and other relevant people participating in the elaboration or implementation of the care plan. It should also include the patient´s signature and the dates when the care plan was discussed with the patient and the date agreed for the next review of the care plan.

5) Instructions for collection and filling of the information contained in the care plan.

The care plan can be completed electronically or handwritten.

The information for the completion of the care plan should be collected by the Named Nurse during the first two weeks following admission of the patient to the psychiatric inpatient unit, and a draft plan should be prepared in collaboration with the patient whenever possible.

Then the drafted care plan should be discussed and agreed in the next MDT meeting with the participation of the patient, whenever possible, and be signed by all relevant parties involved in the elaboration and discussion of the care plan. When the patient refused to participate or for whenever reason it is not possible, this should be documented in the clinical notes and in the section "Comments/Information" of the care plan.

This care plan model could also be used for community patients when considered convenient.

7) Review of the care plan.

The care plan should be reviewed and updated in whenever areas that might be relevant at least every four weeks for patients in the acute wards and every eight weeks for patients in the rehabilitation or long term wards.

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Tel: +350 20078807 Fax: +350 20040045

DISCHARGE LETTER

Date: _____

Dear Dr: _____

Please find below the following information related to the admission of this patient.

ADMINISTRATIVE INFORMATION:

Name: _____ DOB: _____ GHA No: _____
Address: _____
Responsible Consultant: _____ GP Group: _____
Named Nurse: _____

Date of Admission: _____
Date of Discharge: _____
Legal Status During Admission: _____

DIAGNOSIS: _____ ICD-10 Code: F_____

REASON FOR ADMISSION: _____

PROGRESS DURING ADMISSION:

RISK ISSUES IDENTIFIED: _____

DISCHARGE PLAN:

Follow-up: _____

Yours sincerely

Dr _____
Consultant Psychiatrist
CC: GP___ CMHT ___MWO ___Psychologist ___Clinical notes ____Other: _____

MEDICAL IN CONFIDENCE

Ocean Views Mental Health Facility
Europa Road
Gibraltar

Tel: -350-20078807
Fax: -350-20040045

Hospital Ref: _____ Date: ____. ____ ____

Name of GP: _____

_____

C.C: CMHT Team*: MWOs*:

INTERIM DISCHARGE LETTER

Name: _____ D.O.B: _____

Address: _____

_____

Date of Admission: _____

Date of Discharge: _____

This is to notify you that the above named was discharged from hospital today. He / she is fit to return to work / remains unfit for work for a further period of _____ days*

Diagnosis _____ ICD-10 code: F_____

_____

Medication: _____

_____

_____

He / she has been given 14 days supply of medication*

Follow-up arrangement: OPD appointment on _____at _____hrs

Yours sincerely

Dr A.Segovia A Lillywhite Dr A.Diaz J Ruiz
Consultant Psychiatrist