Care Quality Commission

Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Millview
Ward(s) visited:	Millview Lodge
Ward types(s):	Ward for older people with mental health problems
Type of visit:	Unannounced
Visit date:	26 July 2017
Visit reference:	37944
Date of issue:	04 August 2017
Date Provider Action Statement to be returned to CQC:	24 August 2017

What is a Mental Health Act monitoring visit?

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. We do this by looking across the whole patient pathway experience from admissions to discharge – whether patients have their treatment in the community under a supervised treatment order or are detained in hospital.

Mental Health Act Reviewers do this on behalf of CQC, by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers, and they review records and documents.

This report sets out the findings from a visit to monitor the use of the Mental Health Act at the location named above. It is not a public report, but you may use it as the basis for an action statement, to set out how you will make any improvements needed to ensure compliance with the Act and its Code of Practice. You should involve patients as appropriate in developing and monitoring the actions that you will take and, in particular, you should inform patients of what you are doing to address any findings that we have raised in light of their experience of being detained.

This report – and how you act on any identified areas for improvement – will feed directly into our public reporting on the use of the Act and to our monitoring of your compliance with the Health and Social Care Act 2008. However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.

Our monitoring framework

We looked at the following parts of our monitoring framework for the MHA

Domain 1 Assessment and application for detention		Domain 2 Detention in hospital		Domain 3 Supervised community treatment and discharge from detention	
☐	Purpose, respect, participation and least restriction	☒	Protecting patients' rights and autonomy	☐	Purpose, respect, participation and least restriction
☐	Patients admitted from the community (civil powers)	☒	Assessment, transport and admission to hospital	☐	Discharge from hospital, CTO conditions and info about rights
☐	Patients subject to criminal proceedings	☐	Additional considerations for specific patients	☐	Consent to treatment
☐	Patients detained when already in hospital	☒	Care, support and treatment in hospital	☐	Review, recall to hospital and discharge
☐	Police detained using police powers	☒	Leaving hospital		
		☒	Professional responsibilities		

Findings and areas for your action statement

Overall findings

Introduction:

Millview Lodge is a mixed sex assessment ward for older people with functional mental health problems. The ward had nine beds. On the day of our visit there were eight patients allocated to the ward, five were female patients and three male patients. Seven patients were detained under the Mental Health Act 1983 (MHA). One patient was informal.

All patients' rooms had en suite toilets and wet room style shower facilities. There were four female and four male bedrooms on opposite sides of the communal area. The ninth bedroom was on the corridor near the nursing office and could be used for either gender. There were also two separate bathrooms, one with an assisted bath.

On the day of our visit due to the increased number of female patients, one female patient had a bedroom next to the male patient bedrooms. The ward had a female only lounge.

The deputy ward manger told us that baseline staffing for the ward was two qualified nurses and two healthcare assistants for an early and late shift. On a night shift the baseline staffing numbers were one qualified nurse and two healthcare assistants. On the day of our visit there were three qualified nurses on the early shift; one nurse was on a phased return to work. There were two healthcare assistants. One patient was on constant observations and all other patients were on general observations.

The ward had one consultant psychiatrist who acted as responsible clinician (RC) for the patients. Staff told us that the RC was based on the ward or within the building full time so was available to meet patient's clinical needs. The RC attended the daily clinical review for handover about the patient's presentation. There was no junior doctor allocated to the ward at the time of our visit.

How we completed this review:

This was a scheduled unannounced visit to the ward by a Mental Health Act Reviewer. On arrival we were met by the deputy charge nurse who gave us a tour of the ward. We interviewed the deputy charge nurse.

One patient completed a patient engagement form. We met with six patients in private, the other two patients declined to meet with us. We reviewed three patients' records.

We gave verbal feedback to the deputy charge nurse at the end of our visit.

What people told us:
Patients spoke about staff on the ward and told us “staff are good and they are about if I need them”, “staff are excellent they listen to you”, “some staff are helpful and some aren’t” and “some staff are nice enough, some aren’t very nice”. Patients we spoke to told us they felt the ward was kept to a clean standard. Patients spoke about food and told us, “food there’s a good variety” and “meals are good, nice and tasty”. We met staff informally throughout our visit. They told us they enjoyed working on the ward and raised no concerns.
Past actions identified:
The previous MHA monitoring visit was on 26 January 2016. The following issues were identified: • We did not find evidence that detained patients were given section 132 information about their rights on a regular basis even where the record showed that the patient had not understood previous attempts. However the three patients who met with us in private did have a basic understanding of the possible length of their detention but were less clear about the right to appeal or to meet with an independent mental health advocate (IMHA). This issue remained and will be discussed later in this report. • We did not find evidence that patients had signed section 17 leave forms or that they or carers had been given copies of the form. Some carers were escorting their family member on leave and did need to be aware of their potential responsibilities. Some section 17 leave forms had not been crossed through or marked as discontinued. We saw a few examples where two forms had overlapping dates but different leave allowances. This issue remained and will be discussed later in this report.

Domain areas

Protecting patients' rights and autonomy:

We reviewed three patients' records to find out whether they had been informed of their legal positon and rights as required under the MHA section 132. We found differences in the sample of records viewed. One patient had no section 132 rights form completed since their admission but we found a brief note in the running records to state section 132 rights had been read. However, it was not clear how the rights had been read, what information the patient had received and whether an IMHA referral had been made. There were no records to indicate any repeated attempts to inform the patient of their section 132 rights.

In the second patients records we viewed we found there was no record of the patient being informed of their section 132 rights since admission when it was recorded that they did not understand the information. CQC had made a visit the week prior to this visit to do a focus group and had met with this patient who had requested to be informed of their section 132 rights, to receive a list of solicitors and to have an IMHA referral. We found no record these were actioned. An IMHA referral had only been made for the patient five days after this request.

In the third patient's records we viewed we found the patient had been informed of their section 132 rights on admission but had not been given information on solicitors they could contact. There were no further attempts of section 132 rights being provided to this patient even though they were recorded as having not understood when being informed of their section 132 rights on admission. There was no reference to whether a referral to the IMHA service was made. Issues around patients being informed of their section 132 rights was highlighted on our previous MHA monitoring visit in 2016.

We saw relevant information on display around the ward and information on how to complain and how to contact the IMHA service.

The deputy charge nurse told us there was an IMHA service available to patients. There was no automatic process by which patients lacking capacity to instruct an IMHA were automatically referred to the IMHA service. Staff told us the IMHA service visited the ward and met with patients individually. Staff told us there was timely access to the IMHA service and raised no concerns.

The deputy charge nurse told us there was a staff member identified who provided patient's carers with support through home visits or support when they visited the ward. The ward had previously run carer support groups but told us that the attendance at these meetings was low.

Patients we met throughout our visit did not raise any concerns about their bedroom areas. One patient told us that they felt a shelf or somewhere to hang their towel when showering in their en suite would be helpful. No patients had their own bedroom keys. We were told this was in the process of being addressed and that

patients would have their own individual bedroom fobs to access their rooms. The deputy charge nurse told us this would be in place by September 2017. We found this to be a blanket restriction which had not been individually risk assessed.

The ward was mixed sex. On the day of our visit there were more females to male patients which had meant that one female patient had a bedroom within the male side of the communal area. This was not raised as a concern by the patient. Staff told us this had been risk assessed. The bedrooms each had their own en suite washing facilities. However it demonstrated that an appropriate level of gender separation became more difficult to achieve when the ward was fully occupied. The ward had a female only lounge.

There was a garden area available to patients on the ward. This area was unlocked to all patients to provide access to fresh air or to smoke when they wished without staff assistance. This area was locked off for a short time during our visit to allow for the construction of a new summer house for patients. During this time patients were escorted within the garden area.

Patients had access to a communal lounge area with a television. There were facilities available for patients to be able to make their own hot and cold drinks in a kitchen.

Patients were able to access their own mobile phone on the ward. Staff also confirmed that patients could access the staff cordless phone to make private calls to their solicitors and CQC. Patients did not have personal access to the internet on the ward.

Assessment, transport and admission to hospital:

We found detention documents were available for scrutiny. We found approved mental health professional (AMHP) reports were present where these were required. On the patient records we reviewed, all detention documents appeared in order.

Patients were admitted to the hospital from a range of settings. The deputy charge nurse told us that patients were admitted from their own homes, residential homes, supported living and occasionally the general hospital.

The deputy charge nurse told us that all staff received mandatory Mental Capacity Act and MHA training. The deputy charge nurse told us that three staff members were due to have their Mental Capacity Act training update as they were out of date with this training. Staff compliance with MHA training was not clear therefore the deputy charge nurse was not able to provide us with this information.

Additional considerations for specific patients:

Not covered on the day of our visit.

Care, support and treatment in hospital:

We did not find any record of the RC making a record of patients' capacity to consent to treatment on admission in the three patient records we reviewed.

We saw information on display in the main communal patient area on the ward of weekly activities that took place. On the day of our visit it displayed to patients there was an 'out and about group', 'pampering group' in the afternoon and a 'music group' on in the evening. During our visit we did not see these activities taking place. The deputy charge nurse told us that the activities changed on a daily base to meet patient's needs. We found it difficult in the patient's records to see what activities patients were offered to participate in. Some patients told us there were not many activities or things to do. Other patents told us of some craft activities and activities they could do with other patients such as playing cards.

Staff told us that patients remained registered with their general practitioner (GP). There were no concerns raised by staff or patients about arranging or accessing GP services.

Patients received a physical health check by the doctor on the ward on admission. We found this was recorded on the patient's records we reviewed. We also found records of the doctor liaising with the patient's GP on issues such as medication.

We viewed the care plans for three patients. For two patients we were not able to find any copies of any care plans to support their care and treatment. For one patient we found care plans in place but found these had not been signed by the patient and lacked patient and/or carer views. We found no discharge care plans in place in any of the three patients' records we viewed.

Two patients had a risk safety plan in place which included a risk management plan. For one patient we found no record of a risk assessment or risk management plan in place.

Leaving hospital:

In the three patient records we reviewed, all patients had some section 17 leave in place. We were unable to find record that leave was authorised by the RC on the basis of a risk assessment. For one patient we found a note on the day of our visit in the patient's running record to grant the patient some leave but there was no reference to explain how this had been risk assessed. We found no section 17 leave authorisation form in place for this leave.

We were unable to find record of whether patients received a copy of their section 17 leave authorisation form as this area on the sample we viewed had been left blank. We were unable to find record of whether other relevant people had received a copy of the section 17 leave form. We found for one patient two section 17 leave authorisation forms in place which overlapped on dates but had different leaves. This was an issue we found on our previous MHA monitoring visit.

The deputy charge nurse told us that when patients were discharged this was back

to their own homes where possible. If this was not possible, settings such as supported accommodation and specialist services were considered and accessed.

Professional responsibilities:

The deputy charge nurse told us that all nursing staff were trained in how to admit patients onto the ward and check the relevant detention paperwork. They told us nurses had a checklist in place to support this process and that the MHA administration department completed the scrutiny of the detention records.

Tribunals and hospital manager's hearings took place when required.

Other areas:

We observed several ligature points around the ward; vents, lights, window handles and taps. The deputy charge nurse was already aware of these and confirmed there was a ligature risk assessment and plan in place. We did not view this risk assessment. The deputy charge nurse told us there was work to be completed within this financial year to address the ligature points on the ward.

We were also told there was an incident on the ward involving a patient pulling a wardrobe over and due to this changes were to take place to have new wardrobes fitted which would be fixed to the wall.

We found the doors between the patient bedroom and en suite had been removed in all the rooms following an incident and replaced with curtains. The deputy charge nurse told us they understood there were plans to refit doors to these areas.

Section 120B of the Act allows CQC to require providers to produce a statement of the actions that they will take as a result of a monitoring visit. Your action statement should include the areas set out below, and reach us by the date specified on page 1 of this report.

Domain 2 **Protecting patients' rights and autonomy**	**MHA section:** 132 **CoP Ref:** Chapter 4
We found:	
We reviewed three patients' records to find out whether patients had been informed of their legal positon and rights as required under the MHA section 132. We found differences in the sample of records viewed. One patient had no section 132 rights form completed since their admission but we found a brief note in the running records to state section 132 rights had been read. However, it was not clear how the rights had been read, what information the patient had received and whether an IMHA referral had been made. There were no repeated attempts of the patient being informed of their section 132 rights. In the second patients record we viewed we found there was no record of them being informed of their section 132 rights since admission when it was recorded that they did not understand the information. CQC had made a visit the week prior to this visit to do a focus group and had met with this patient who had requested to be informed of their section 132 rights, to receive a list of solicitors and to have an IMHA referral. We found no record these were actioned. An IMHA referral had only been made for the patient five days after this request. In the third patient's records we viewed we found had been informed of their section 132 rights on admission but had not been given information on solicitors they could contact. There were no further attempts of section 132 rights being provided to this patient even though they were recorded as having not understood when being informed of their section 132 rights on admission. There was no reference to whether a referral to the IMHA service was made. Issues around patients being informed of their section 132 rights was highlighted on our previous MHA monitoring visit in 2016.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice paragraph 4.28: "Those with responsibility for patient care should ensure that patients are reminded from time to time of their rights and the effects of the Act. It may be necessary to give the same information on a number of different occasions or in different formats and to check regularly that the patient has fully understood it. Information given to a patient who is unwell may need to be repeated when their condition has improved. It is helpful to ensure that patients are aware that an IMHA can help them to understand the information (see paragraph 6.12)."	

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 6
We found:	
There was no automatic process by which patients lacking capacity to instruct an IMHA were automatically referred to the IMHA service.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice paragraph 6.16: "If a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly."	

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 8

We found:

We found a couple of blanket restrictions in place which had not been individually risk assessed;

- No patients had their own bedroom keys. We were told this was in the process of being addressed and that patients would have their own individual bedroom fobs to access their rooms. We were told by the deputy charge nurse this would be in place by September 2017.
- Patients did not have personal access to the internet on the ward.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs 8.5:

> "In this chapter the term 'blanket restrictions' refers to rules or policies that restrict a patients liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records."
>
> and 8.7
>
> "Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights."

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 24
We found:	
We did not find any record of the RC making a record of patients' capacity to consent to treatment on admission in the three patients' records we reviewed.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice paragraph 24.41: "During this time, the patients consent should still be sought before any medication is administered, wherever practicable. The patients consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment."	

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapters 1, 24 and 34

We found:

We viewed the care plans for three patients. For two patients we were not able to find copies of any care plans to support their care and treatment. For one patient we found care plans in place but found these had not been signed by the patient and lacked patient and/or carer views. We found no discharge care plans in place for any of the three patients' records we viewed.

Two patients had a risk safety plan in place which included a risk management plan. For one patient we found no record of a risk assessment or risk management plan in place.

We found it difficult in the patient's records to see what activities patients were offered on a daily basis to participate in.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs 1.7:

> "Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient."
>
> and 24.49
>
> "Wherever possible, the whole treatment plan should be discussed with the patient. Patients should be encouraged and assisted to make use of advocacy support available to them, if they want it. This includes, but need not be restricted to, independent mental health advocacy services under the Act. Where patients cannot (or do not wish to) participate in discussion about their treatment plan, any views they have expressed previously should be taken into consideration."
>
> and 34.10
>
> "Most importantly, the care plan should be prepared in close partnership with the patient from the outset, particularly where it is necessary to manage the process of discharge from hospital and reintegration into the community."

Domain 2 **Leaving Hospital**	**MHA section:** 17 **CoP Ref:** Chapter 27

We found:

In the three patient records we reviewed, all patients had some section 17 leave in place. We were unable to find record that leave was authorised by the RC on the basis of a risk assessment. For one patient we found a note on the day of our visit in the patient's running record to grant the patient some leave but there was no reference as to how this was risk assessed. We found no section 17 leave authorisation form in place for this leave.

We were unable to find record of whether patients received a copy of their section 17 leave authorisation form as this area on the samples we viewed had been left blank. We were unable to find record of whether other relevant people had received a copy of the section 17 leave form. We found for one patient two section 17 leave authorisation forms in place which overlapped on dates but had different leaves. This was an issue we found on our previous MHA monitoring visit.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs 27.22:

> "Hospital managers should establish a standardised system by which responsible clinicians can record the leave they authorise and specify the conditions attached to it. Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know. A copy should also be kept in the patients notes. In case they fail to return from leave, an up to date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patients consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA))."

During our visit, patients raised specific issues regarding their care, treatment and human rights. These issues are noted below for your action, and you should address them in your action statement.

Individual issues raised by patients that are not reported above:

Patient reference	B
Issue:	
Patient B told us that they did not wish to raise this as a complaint or an issue but explained they felt it would be beneficial to have somewhere to store their towel and clothes in the en suite wet rooms. Please advise if this could be actioned.	

Patient reference	C
Issue:	
Patient C had recently been admitted to the ward and told us that they were unable to sleep the previous night to our visit due to being cold in bed. The deputy charge nurse told us on the day of our visit that this was being addressed and the patient was to be given more bedding and blankets. Please meet with the patient and update us of the outcome.	

Patient reference	E
Issue:	
Patient E was very unhappy about being on the ward and wanted to have a list of solicitors so that they were able to contact a solicitor and appeal their section. They also wanted staff to meet with them to explain what was happening and their care plan. Patient E further wanted to know from staff why on occasions they refused them the tramadol medication which was prescribed. The deputy charge nurse agreed to action this on the day of our visit. Please meet with the patient and update us of the outcome.	

Information for the reader

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Audience	Providers
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