Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Newbridges, Birkdale Way, New Bridge Road, Hull, Humberside. HU9 2BH
Ward(s) visited:	Newbridges
Ward types(s):	Acute ward for adults of working age
Type of visit:	Unannounced
Visit date:	31 May 2016
Visit reference:	36208
Date of issue:	22 June 2016
Date Provider Action Statement to be returned to CQC:	12 July 2016

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 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Newbridges is situated in a residential area of East Hull and has 18 beds for the admission and treatment of men with mental health diagnoses. Patients were transferred from other wards within the trust or were admitted directly onto the ward. On the day of the visit there were 20 patients allocated to the ward. Three were on leave. 17 beds were available as one bedroom was being refurbished. Thirteen patients were detained under the Mental Health Act. One patient was in the seclusion room.

On the day of our visit there were two registered nurses and three healthcare workers on duty. The activities coordinator was working as a bank healthcare worker. The team was supported by an occupational therapy (OT) assistant. There was also an assistant psychologist and a deputy charge nurse on the unit. The unit had a locum consultant psychiatrist who acted as the responsible clinician (RC) and had worked there for a year.

The unit was undergoing refurbishment work following a fire in March 2016. One bedroom was out of service due to the fire and was being renovated. The patient kitchen was being re-fitted, and the clinic room was being moved, leaving the former clinic for use as a quiet room. The dining room had been extended as it was too small to accommodate 18 patients at one sitting. Plans to refurbish the seclusion room (which was in the area undergoing refurbishment) were on hold due to the wait to transfer the secluded patient to a more appropriate environment in a psychiatric intensive care unit (PICU).

How we completed this review:

We made an unannounced visit to the unit. We met with two detained patients in private and spoke to other patients as we looked around the unit. We spoke briefly with the patient in seclusion but they did not wish to talk to us. We gave out questionnaires to all detained patients and received six patient responses.

We talked with a range of staff and reviewed six files.

We looked around the unit facilities.

What people told us:

Patients told us staff were great but there were not enough staff to work with 18 patients. They did not like the use of pool staff as this meant too many changes, making it hard to build up trusting relationships with staff. They said it was difficult to have their entitlement of escorted section 17 leave due to staffing levels. They told

us that there was very little to do on the unit. They said they were not involved in developing their care plans or discharge planning. Some detained patients said they had been given little information about their rights and medication. They said they did not have one to one sessions with their named nurse or key worker. They said their rooms were basic and in need of redecorating.

Some patients felt unsafe on the unit due to other patients' behaviour at times. They thought the unit was too big and felt overwhelmed when they moved in from smaller trust units. They said they did not find the unit conducive to recovery.

Staff told us the team was very supportive to work in. However they said there were staffing issues. They found it hard to recruit and retain staff and used bank staff to cover shifts for vacancies and sick leave. They said morale was low as they did not feel able to offer the best care to patients as a result of staffing problems. They were uncertain about the future due to the potential impact of the Chief Executive's resignation and the recent CQC comprehensive inspection. They did not feel supported by senior management who did not see the problems in service delivery at first hand.

They said staff had been offered support following recent incidents including a serious fire which was one of two fire setting incidents on the unit. A member of staff had been hospitalised due to smoke inhalation. They and their family felt well supported by the trust.

The refurbishment work had been difficult to manage whilst providing a service. The work on the seclusion room, within the area being renovated, was delayed due to its being occupied. Staff said it took time for estates to respond to requests for building repairs. They praised the domestic worker's commitment to looking after the unit. We found a good standard of cleanliness in the toilets and bathroom areas. Six of the bedrooms were en suite due to previous work in late 2014 to expand the bed numbers from 12 when another unit closed. 17 bedrooms were on the first floor. There was a range of toilet, shower and bathroom facilities including a shower room for people with disabilities. One bedroom could be separated from the other rooms and accessed by its own staircase if there was an urgent need to admit a younger person.

Staff were concerned about the delays in finding the best facility for the patient in seclusion. They knew the patient from previous admissions and said he was very unwell. The noisy environment of refurbishment work going on around him was not ideal. The modern matron was trying to expedite his transfer to the PICU.

Staff said they held formulation groups and reflective practice groups with input from psychology. The deputy charge nurses undertook regular defensible documentation audits and put the results in each file, praising the positives and pointing out the gaps. Staff could no longer use the electronic Galatean Risk And Safety Tool (GRiST) as it had broken in April. They were using a paper based alternative. Staff told us the trust's mental health steering group no longer had input from band five or six practitioners. They saw this as a backward step.

Past actions identified:
We visited on 11 December 2014 prior to the unit's expansion to 18 beds. We found patients did not have keys to their rooms or a place to secure their belongings. We asked how the trust would enable patients to secure their belongings in a way that was compatible with the least restriction principle of the Code of Practice. On this visit we found this was still the case and raise it again below. On our last visit we found the care plans available in the patient's notes were not person centred and did not reflect the patient's treatment pathway. Whilst there were CPA meetings we could not find how these related to the current treatment plan. On this visit we found the recovery star care plan was still in use. Patients told us they were not involved in developing their care plans and did not have copies. We raise this below. On our last visit we raised issues relating to seclusion. The trust had produced an updated seclusion and long term segregation policy in January 2016. We raise below the issues relating to seclusion practice on this visit. On our last visit we found that there were no assessments of a patient's capacity to consent to treatment, either on admission to the ward or at first administration for treatment for mental disorder and that the completed form that we saw did not clearly state what the assessment of capacity was in relation to. On this visit we found some improvements in relation to assessments of capacity relating to specific issues but could not find a record of the RC's discussion with patients in relation to determining whether the patient had capacity to consent to medication under section 58 procedures. We discussed this with the RC during our visit and raise this as an action point below.

Domain areas

Protecting patients' rights and autonomy:

Some detained patients told us staff had not fully explained their rights or medication to them. We found staff gave patients information as required by section 132 on admission to a Humber trust facility and if a patient admitted on section 2 was later detained on section 3. However there was no evidence of repeated rights information sessions on the files that we reviewed. Information about section 132 rights for detained patients and the independent mental health advocacy (IMHA) service were on display in the corridor. Staff said they referred patients who did not have capacity to make that decision to the IMHA. The latter attended meetings on the unit if required.

Patients said they were not involved in developing their care plans or discharge planning. They said staffing shortages and the use of bank staff meant that staff had too little time to engage with them or to facilitate escorted section 17 leave. They said there was little to do on the unit.

Some patients told us they felt unsafe on the unit due to other patients' behaviour at times. They thought the unit was too big and felt overwhelmed when they moved in from smaller trust units. They said they did not find the unit conducive to recovery. Some patients said they did not have one to one sessions with their named nurse or key worker. We found only one session with their key worker on one patient's file. The patient had been in hospital for six weeks.

Patients were able to keep their mobile phones but were reminded not to use the camera. They did not have direct access to the internet on the unit. The door to access the building was locked. All patients were asked to talk to staff and detained patients were informed that they could only leave with authorised section 17 leave in place. Staff gave informal patients information about their rights.

The trust did not offer training to staff about the Mental Health Act (MHA) and their responsibilities.

Staff told us that two staff were nominated as carers' champions. They hoped to run weekly carers groups soon to support carers. We saw evidence on files that patients were asked for permission to involve their carers during their inpatient stay. Carers were invited to a reception meeting and then to other care planning meetings with patients' agreement.

Assessment, transport and admission to hospital:

We found no detention documents on one patient's file. Staff could not access the documents during our visit. We could not find evidence of detention on a second file but saw that the detention period had ended. We did not find a record that the RC had revoked detention but further examination of the notes revealed that the patient had been re-graded to informal status.

We found that detention documents with approved mental health professional (AMHP) reports were in order on the remaining four files.

Additional considerations for specific patients:

We did not review this area.

Care, support and treatment in hospital:

Staff used the recovery star to develop and review patients' care plans. Patients' views about their care were included. We saw evidence that the multi-disciplinary team reviewed patients' care regularly but patients told us they were not involved in developing or reviewing their care plans and did not have copies.

We found that practice in relation to capacity assessments for specific decisions had improved. However the RC had not recorded his discussion with two patients to decide whether they had capacity to consent to medication under section 58 requirements prior to prescribing medication on form T2. We discussed this with the RC during our visit.

A detained patient absconded during our visit by breaking a window. Staff alerted the police and brought him back from the police station. There had been recent incidents including two fires, one of which caused serious damage and hospital treatment for a staff member. Some staff expressed concern that incidents were related to insufficient staffing levels. They thought that some incidents were avoidable if there had been a higher staff to patient ratio. They gave as an example, being asked to escort a patient for medical attention with one other staff member. Prior to taking the patient they said the patient needed more staff to escort them. No additional staff were available. During the escorted leave an incident took place. The staff member thought the incident, resulting harm to the patient and associated distress for involved staff could have been avoided with better escort arrangements.

One detained patient had been in the seclusion room for six days after treatment at Hull Royal Infirmary for fluid retention whilst in seclusion. We were concerned to find that nursing reviews of seclusion had not taken place every two hours as required by the Code of Practice and the trust's policy. Staff had not received training on seclusion practice. We were aware that reviews by two registered staff could not take place during night shifts if the nursing levels establishment meant that only one registered staff member was on duty. This meant that the staff could not meet required standards but our review found that reviews were missing during early and late shifts too. We did not see fully completed fluid charts despite a medical entry that the patient might need a medical admission if they did not have more fluid intake and output over two days. We understand the difficulties of accurate documenting if the patient was not cooperative but staff should make attempts to measure these. We asked to see other seclusion records for another patient but their complete detention documents could not be found during our visit.

Patients had differing views about whether their medication's benefits and risks had

been explained to them.

Leaving hospital:

Patients were not clear how they would demonstrate that they were ready to leave hospital and felt they were just marking time. They were concerned they could not have regular escorted section 17 leave or use their days in constructive activities due to staffing levels. The recovery stars showed patients making progress but discharge goals were not clear. Staff told us they could no longer use the electronic GRiST tool as it had broken in April. They were using a paper based alternative which they did not find adequate. They did not know when this would be fixed.

Other agencies were involved in meeting patients' needs on discharge. We saw evidence that the unit had more patients than beds and sent patients on leave to manage bed numbers. Staff said some patients were placed in voluntary sector accommodation to manage beds. They did not think this was in patients' best interests.

Professional responsibilities:

The deputy charge nurses undertook regular defensible documentation audits of patients' files. We saw copies of the outcomes, clearly marking positives and areas for improvement on files. However we did not see evidence that this made a difference, for example in section 132 compliance which was not in line with the Code of Practice. We also heard about staff shortages which might inhibit improvements in practice.

We were concerned that staff were not aware that one patient's detention documents were not on the file. This meant the unit had no evidence supporting their right to detain the patient. We also did not find evidence that one patient's detention had been revoked, meaning they were an informal patient.

Staff were not adhering to the requirements of the Code of Practice or the trust's current seclusion policy.

We did not find how the hospital managers ensured they were meeting their responsibilities in these areas by auditing and reviewing practice throughout the trust.

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: Chapters 1, 4, 37**

We found:

Staff did give patients information about their rights as required by section 132 on admission. However we found little evidence that information was repeated as required by the Code of Practice. Although file audits were undertaken on the unit, we did not find evidence of improvements in practice as a result.

Your action statement should address:

How you will ensure that patients are given information about their rights as required by the Code of Practice which states:

Paragraph 4.28 states:

> 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 understood it. Information given to a patient who is unwell may need to be repeated when their condition has improved.

How you will ensure that hospital managers are meeting their responsibilities towards detained patients as stated in the Code of Practice:

Paragraph 37.3 states:

> Hospital managers have the authority to detain patients. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

and paragraph 37.11 states: ‘The organisation (or individual) concerned should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf. ‘

Domain 2 Assessment, transport and admission to hospital	CoP Ref: Chapter 37
We found:	
The detention documents were missing on one patient's file. The unit could not access copies of these documents on the day of our visit and so could not verify the patient's detention. On another file we found the patient had been regraded as informal but the paperwork to verify this change was not present with the detention documents.	
Your action statement should address:	
What steps you will take to ensure that all documents authorising detention are present on the unit's files for detained patients. How the trust will confirm that for all the detained patients currently on the ward, the trust has evidence of legal authority to detain.	

Domain 2 Care, support and treatment in hospital	CoP Ref: Chapters 1,26
We found:	
Patients told us there were insufficient staff to support them during their admission. They said they did not have one to one time with their key worker as a result. They told us they were not involved in care or discharge planning. They said escorted section 17 leave could not be facilitated often enough to promote recovery. They did not feel safe at times on the ward. There was little to do.	
Your action statement should address:	
What steps you will take to ensure patients are offered treatment and care in line with the five guiding principles of the Code of Practice (1.2 to 1.24) What steps you will take to ensure that care is offered in line with the primary preventative strategies outlined in Chapter 26 (26.18 to 26.23) of the Code of Practice	

Domain 2 Care, support and treatment in hospital	MHA section: 58 CoP Ref: Chapter 25
We found:	
No record on patients' notes of the RC's discussion with them about their medication to establish their capacity to consent to treatment under forms T2.	
Your action statement should address:	
What action you will take to ensure that RCs meet the requirements of the Code of Practice paragraph 25.17 which states: 'Where approved clinicians certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to treatment. A record of their discussion with the patient including any capacity assessment should be made in the notes as normal.'	

Domain 2 Care, support and treatment in hospital	CoP Ref: Chapter 26
We found:	
Concerns in the management of the patient in seclusion. Nursing staff had not reviewed the patient every two hours in line with the trust's seclusion policy and the Code of Practice. The patient had received rapid tranquillisation. Fluid input and output were not recorded rigorously, despite the patient's recent problems with fluid retention requiring hospital admission. One multi-disciplinary review consisted of the RC and a nurse. We did not establish whether telephone consultation took place with another professional if this was out of office hours.	
Your action statement should address:	
What action you have taken to audit compliance with the Code of Practice in all episodes of seclusion, in the recent past and in the future. What action you will take to ensure that staff are aware of and have the resources to meet their professional responsibilities to secluded patients in line with paragraph 26.134 of the Code of Practice which states: 'Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been directly involved in the decision to seclude.' And paragraph 26.122 'For patients who have received sedation, a skilled professional will need to be outside the door at all times.'	

Domain 2 Care, support and treatment in hospital	CoP Ref: Chapters1, 8, 26
We found:	
We visited on 11 December 2014 prior to the unit's expansion to 18 beds. We found patients did not have keys to their rooms or a place to secure their belongings. We asked how the trust would enable patients to secure their belongings in a way that was compatible with the least restriction principle of the Code of Practice. On this visit we found this was still the case and raise it again below. We were concerned that this was a blanket restriction rather than one based on risk assessment for reach patient.	
Your action statement should address:	
What action you will take to meet the requirements of paragraph 1.6 of the Code of Practice which states: 'Restrictions that apply to all patients in a particular setting (global or blanket restrictions) should be avoided.' And paragraph 8.24 'Hospitals should provide adequate storage in lockable facilities (with staff override) for the clothing and other personal possessions which patients may keep with them on the ward and for the secure central storage of anything of value or items which may pose a risk to the patient or others, e.g. razors.' And paragraph 26.18 'giving each patient a defined personal space and a safe place to keep their possessions.'	

During our visit, no patients raised specific issues regarding their care, treatment and human rights.

Information for the reader

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Audience	Providers
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