Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated Individual:	Jules Williams
Region:	North
Location name:	Willerby Hill
Location address:	Beverley Road, Willerby, Hull, Humberside. HU10 6ED
Ward(s) visited:	Humber Centre Forensic Unit: Derwent
Ward type(s):	Medium secure
Type of visit:	Unannounced
Visit date:	5 February 2016
Visit reference:	35621
Date of issue:	12 February 2016
Date Provider Action Statement to be returned to CQC:	03 March 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 admission 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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	☒	Purpose, respect, participation and least restriction	☐	Purpose, respect, participation and least restriction
☐	Patients admitted from the community (civil powers)	☒	Admission to the ward	☐	Discharge from hospital, CTO conditions and info about rights
☐	Patients subject to criminal proceedings	☐	Tribunals and hearings	☐	Consent to treatment
☐	Patients detained when already in hospital	☒	Leave of absence	☐	Review, recall to hospital and discharge
☐	People detained using police powers	☐	Transfers		
		☒	Control and security		
		☒	Consent to treatment		
		☒	General healthcare		

Findings and areas for your action statement

Overall findings

Introduction:

Derwent ward is a 10 bed medium secure admission ward for males, situated in the Humber Centre secure unit. The nine patients on the ward were admitted from the criminal justice system, on a variety of remand and treatment sections.

There were two registered nurses and three health care assistants (HCA's) on duty working a long day shift pattern. Another HCA was due to work a twilight shift, with one registered nurse and two HCA's due to cover the night shift. An activity worker supported the ward staff during the day and the unit manager and matron were present at times throughout the day.

The nursing staff were supported by an occupational therapist (OT) who covered the ward and the neighbouring rehabilitation ward. There was one responsible clinician (RC) for all of the patients on the ward, who was supported by a junior doctor. The ward had access to both forensic psychology and clinical psychology.

The patients had access to fresh air in an internal courtyard, which was also the smoking area. The courtyard surface had moss growing on it in places and had piles of cigarette butts. Patients also had access to the garden area enclosed within the perimeter fence through section 17 authorised leave.

How we completed this review:

We made an unannounced visit to the ward, where we spoke to four patients in private. We spoke informally with staff and we toured the ward. We reviewed four sets of clinical records, including the detention documents. At the end of the visit we gave informal feedback to the staff nurse, unit manager and matron.

What people told us:

Some patients were generally very positive about the ward and staff. We were told:
"I've had a really good admission. Coming to the ward from the prison system was brilliant for me."
"There are plenty of things here to benefit me."
"I'm happy here. It's like a family on this ward."
"Staff are easy to approach and talk to"

Other patients, were more reserved in their comments:
"Staff are okay."
"[Staff} are doing the job. The nurses are average"
"I'm making progress."

“The food is okay.”

Staff told us that the recent changes to the ward management was just beginning to make a difference. Staff told us of some of the improvements to clinical practice that they were looking to bring in, including patient-centred care planning, positive behaviour support plans and the Safewards model for conflict reduction. We were told that staff had requested improvements to the ward facilities, but that upgrade programmes had been stopped because of a service-wide review and trust financial constraints. We were told:
“Here, the environment is really quite dire.”
“The smell [in the shower room] is not as bad as it usually is.”

Past actions identified:

On our last visit to the ward on 21 August 2014 we found:

The seclusion room did not have temperature control or adequate ventilation and the window blinds could not be operated by the secluded patient. On this visit we saw that these had been addressed, but that the complete refurbishment of the seclusion area that the trust told us about in their actions had not taken place. Staff told us that this was still under review.

Some care plans did not evidence involvement of the patient in the planning of their care. We found that this was still the case on this visit.

Patients told us that there was not enough to do on the ward due to staffing levels. We found that this had been addressed on this visit.

A care plan indicated that if the patient refused their medication then they should be taken to seclusion. The trust told us that this had been addressed immediately after our last visit. Whilst we did not find the same circumstances on this visit we continue to have concerns about seclusion and there is an action relating to this.

Domain areas

Purpose, respect, participation and least restriction:

Within the ward environment there was no evidence of blanket restrictions in terms of access to areas. There were defined smoking times and times when hot drinks were served. We were told that patients could request hot drinks outside of these times. We were told that the smoking times were there to encourage patients to attend activity sessions rather than smoke. Staff said that if a patient missed a smoking time because they were in a session then staff would be flexible in allowing the patient to smoke.

One patient who was born abroad has been supported with his care plan and his

leave to maintain contact with his local ethnic community. He said that he had been offered a translator at key meetings, even though his English was good.

We found a good range of care plans for all patients. Although the care plans were individual to each patient and regularly updated, the records did not show consistent evidence of patient involvement, even allowing for those patients who were unable to engage effectively.

The staff told us that the ward had a weekly community meeting, which was also attended by the OT and the activity worker. We were also told about a monthly service-wide meeting for patients.

Admission to the ward:

We found that all of the detention and admission documents were in order, with reports from the approved mental health professional (AMPH) where this was required. We saw evidence that patients were informed of their legal rights on admission and that these rights were repeated if the patient was too unwell to understand them.

The records did not provide evidence that patients were informed of the independent mental health advocate (IMHA) when they were eligible, although patients we spoke with were aware of the IMHA, who visited the ward regularly. We did not see contact details of the IMHA service on the ward noticeboard. This did contain details of how to make a complaint and contact the CQC. This noticeboard also contained contact details of the local specialist mental health lawyers.

Tribunals and hearings:

We did not review this domain on this visit.

Leave of absence:

There was a system in place for authorising leave under section 17 of the Mental Health Act 1983 (MHA). Where they were required there were copies of the authorisation of leave from the Ministry of Justice or the court. Expired leave authorisations were removed from the file. There was a process for informing appropriate agencies.

Transfers:

We did not review this domain on this visit.

Control and security:

The physical and operational systems on the ward reflected the level of security required without being obtrusive. Patients who related their experiences of having their bedroom searched all reported that it was done in a respectful manner and their description reflected the requirements of the Code of Practice.

We were told that the use of restraint and seclusion on the ward had reduced over the last two years. One patient told us that he had not seen restraint being used during his time on the ward.

We reviewed one set of seclusion records covering a seclusion of 26 days. The record showed reviews of seclusion that reflected the previous Code of Practice. We were told that the new trust seclusion policy was still being reviewed and was due to have been issued before Christmas.

We were concerned that the seclusion record for this patient and for another patient whose record we reviewed, did not reflect the Code of Practice in relation to the reason for seclusion. We noted that both patients were secluded immediately upon admission to the ward. Both seclusion records suggested that patient engagement with their care plan was a requirement for the lifting of seclusion. Staff told us that this was a reflection of the quality of record keeping rather than the misuse of seclusion.

The seclusion room was adjacent to a corridor, with an observation window from the corridor into the seclusion room. The corridor was also used as an area which could be used by the secluded patients. This did not fully support the privacy and dignity of patients using the room. We saw that the windows from the corridor into the courtyard had been obscured by multiple sheets of A4 size paper. Whilst this was effective it did not reflect that patients using this area were valued.

Consent to treatment:

We found that patients had an assessment of their ability to consent to treatment at 3 months after admission. We could find no assessment prior to this. We noted that there was an assessment by a second opinion appointed doctor (SOAD) when this was indicated.

All the treatments that we reviewed were properly authorised. T2 and T3 certificates were properly completed. One was authorised by a section 62 form as the patient reached the 3 month point. We were informed that a request for a SOAD had been made in good time and had been followed up. There was still no date for a SOAD assessment.

General healthcare:

A general practitioner attended the centre on a regular basis. The trust also

employed a registered general nurse to help manage patients physical health. Nurses from the GP practice also ran specialist clinics such as heart clinics.
Other areas:
The décor on the ward was generally run down, with scratched and flaking paintwork. The communal shower smelt badly and was hot and humid, with a rusting radiator. The internal courtyard was green and mossy.

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 Control and security	**CoP Ref: Chapter 26**

We found:
That the seclusion room had an observation window into the room from the adjacent thoroughfare. The window had no covered that would support the patient's right to privacy and dignity.
Your action statement should address:
How you will ensure the privacy and dignity of patients using the seclusion room. Paragraph 26.110 of the Code of Practice says that the providers policy should "…designate a suitable environment that takes account of the patient's dignity and physical wellbeing..."

Domain 2 Purpose, Respect, Participation, Least Restriction	CoP Ref: Chapter 1

We found:

That care plans reflected the specific needs of patients. Speaking to patients it was clear that those well enough to engage were able to influence their care. However, the care plans we saw did not reflect that there had been any patient involvement in their development, even for patients who were able to engage with the process.

This was also an action from our last visit on 21 August 2014.

Your action statement should address:

How the trust will ensure that any patient involvement in the development of the care is fully reflected in the patient's care plan.

Paragraph 1.7 of the Code of Practice states: "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."

Domain 2 Admission to the ward	CoP Ref: Chapter 4

We found:

That patients were aware of the IMHA service and that the IMHA visited the ward regularly. Although there was comprehensive information for patients on legal representatives, making complaints to the hospital and the CQC, we saw no printed information relating to the IMHA service.

Your action statement should address:

How the trust will ensure that printed information relating to the IMHA service is available to patients.

Paragraph 4.12 of the Code of Practice states that "Patients should be given all relevant information, including on… advocacy… This information should be readily available to them throughout their detention…"

Domain 2 Control and security	CoP Ref: Chapter 26

We found:

That for two of the four records that we reviewed the patient had been admitted directly into seclusion. Neither of the descriptions of the events leading to seclusion reflected the requirements of the Code of Practice for the use of seclusion. The description of the reviews of seclusion rarely reflected a presentation that seemed to justify the continuation of the seclusion episodes.

Your action statement should address:

How the trust will assure us that seclusion is used appropriately in line with the Code of Practice and that long-term segregation is considered when necessary.

How the trust will ensure that the recording of the initiation of seclusion and the reviews of seclusion accurately record the patient's presentation and so justify any subsequent actions.

Paragraph 26.103 of the Code of Practice states that "Seclusion refers to the supervised confinement and isolation of a patient… where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others."

Paragraph 26.150 describes long-term segregation as "…a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation… [and] would not be ameliorated by a short period of seclusion combined with any other form of treatment..."

Domain 2 Consent to treatment	**MHA section: 63** **CoP Ref:** Chapter 24

We found:
That although there were assessments of patients capacity to consent to treatment when treatment was authorised under section 58, we could not see any similar process when patients were first admitted and treated under section 63 of the Act
Your action statement should address:
How the trust will ensure that patients capacity to consent to treatment is assessed throughout their admission and that treatment is given with patient's consent wherever possible. Paragraph 24.41 states that "During … [the initial three month period] the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent or a lack of capacity to give consent should be recorded in the case notes..."

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

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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