Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Willerby Hill
Ward(s) visited:	Darley House
Ward types(s):	Secure ward - Low
Type of visit:	Unannounced
Visit date:	8 March 2017
Visit reference:	37406
Date of issue:	20 March 2017
Date Provider Action Statement to be returned to CQC:	7 April 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Darley House is an eight bedded low secure ward for male patients with long standing treatment resistant mental illness.

On the day of our visit the ward had eight patients, all of these patients were detained under the Mental Health Act (1983) (MHA).

The ward had recently been redecorated throughout. There were two TV lounges, a dining room, which was multi-purpose and used for a variety of activities outside of mealtimes. There was a multi-faith room and a large shared garden area. Patients had their own bedrooms, none were en suite. There were bathrooms, a shower and several toilets.

Baseline staffing for the ward was five staff on a long day to include two qualified nurses. On a night shift there was one qualified nurse and two health care support workers. On the day of our visit, due to clinical need the ward had more staff to support patients on enhanced observations and there was one patient in seclusion. There were two qualified nurses on shift on the day of our visit, six healthcare support workers and a band four healthcare worker.

The acting ward manager was not included in the ward numbers. We found the acting ward manager was covering the ward due to the ward manager being off on long term sick; They also were ward manager for another ward within the Humber Centre.

Patients had access to psychology, occupational therapy, occupational therapy assistants, a social work assistant, art therapist and a speech and language therapist.

The consultant psychiatrist was the responsible clinician (RC) for all of the patients on the ward. The ward manager told us the RC was full time and covered two wards within the Humber Centre. The RC was supported by a full time junior doctor.

How we completed this review:

This was a scheduled unannounced visit to the ward by a Mental Health Act Reviewer. On arrival at the ward we met with the acting ward manager. We had a tour of the unit.

We met with two patients in private, all other patients declined to meet with us. Patient engagement forms were provided and none were returned completed.

We reviewed three sets of patients' records and viewed some seclusion records for episodes of seclusion which had taken place in 2017. We reviewed a sample of records for the patient being nursed in long term segregation.

We met with staff informally and interviewed a band 6 nurse. We tried to contact the independent mental health advocate (IMHA) for the ward but we were not able to make contact in the time period prior to writing this report.

We provided verbal feedback to a band 6 nurse and acting ward manager at the end of our visit.

What people told us:

We spoke with two patients in private, who had different perspectives of their care;

One patient told us when asked about things to do on the ward "there's nothing to do".

This patient spoke about their experience on the ward as negative when asked about staff told us "they're dominant, controlling, there's no trust" but told us "I see my named nurse".

When asked if they felt safe on the ward they told us "I don't feel safe I feel shot at".

Another patient told us "staff are great" and "I can talk to staff". When asked about section 17 leave they told us "I go to the café and shopping in Hull and have no problem with having my leave".

When we asked this patient if they felt safe on the ward they told us "I feel quite safe".

Staff spoke to us informally throughout the day. Staff didn't raise any concerns with us during our visit.

Past actions identified:

The previous MHA monitoring visit was on 29 June 2015. The following issues was identified:

- We did not see a poster displayed on the unit that specifically advised patients about the IMHA service, including contact details.

  This issue was resolved. IMHA information was on display on the ward on the day of our visit.

- We saw information displayed about how to complain about the provider's services and how to contact the PALS. We did not see complaints information displayed about how to complain to the service commissioner, CQC or

Parliamentary and Health Ombudsman.

This issue was resolved. This information was on display for patients on the day of our visit.

- No best interests' assessment setting out the treatment arrangements for patients' assessed as lacking capacity to consent to treatment. We were advised that the MDT discusses the actions to take in the patient's best interests, but this did not appear to include consultation with carers or people nominated by the patient.

  We saw best interests assessments and decisions recorded in the notes for specific decisions where appropriate. We did find some issues in regards to assessment of capacity to consent which will be detailed later in the report and form an action point.

- A standardised care plan intervention in regard to section 132 MHA, which indicated that patients should be given an explanation of their rights weekly or fortnightly, when in fact we were advised by staff that on explanation of rights is undertaken on a monthly basis and the records show that patients were given an explanation of their rights on a monthly basis.

  This issue was resolved. Patients had care plans which detailed when their section 132 rights should be read and this was individualised based on when the patient would require this.

Domain areas

Protecting patients' rights and autonomy:

There was information on display about the independent mental health advocacy (IMHA) service available for patients. Staff told us that patients on the ward were automatically referred to the IMHA if they lacked capacity to instruct an IMHA.

The IMHA visited the ward on a weekly basis and staff told us they met with all patients to offer to support them. The IMHA attended the weekly community meeting where possible. Staff told us that patients have access to a payphone on the ward to contact IMHA but that they could also use the phones off ward for privacy. Patients and staff raised no concerns about access to the IMHA service.

We saw information on display about how to complain and how to contact the Care Quality Commission (CQC).

The ward was locked in line with low secure standards.

We found patients were able to have access to their own mobile phones on the ward. This was required to be risk assessed and approved by the multi-disciplinary team. We found on the day of the visit one patient had chosen to have their mobile phone on the ward. Staff told us that many patients are not bothered about having a mobile phone on the ward. Staff told us that patients had been informed in community meetings that they were able to request to have their mobile phones on the ward and this would need to be discussed and approved through the multi-disciplinary team.

Staff told us that the ward is looking at patients automatically being allowed their mobile phones on the ward on admission unless risk assessment did not allow this. Staff explained that currently, as the ward was the only low secure ward based within the Humber Centre, this was being considered through policy. This was because patients on the low secure ward were potentially vulnerable, as wards in the medium secure area do not currently allow mobile phones on the wards.

We found patients were not able to have personal access to the internet on the ward. Staff told us that patients can access the internet off the ward on the patient computer or if they have a phone that is internet enabled whilst on leave.

Patients had random three monthly room searches in line with low secure standards. Staff told us that no patients have personal searches on return from section 17 leave unless they have been individually risk assessed to require this. No patient had routine room searches and staff told us that this only took place if individual risk assessment required this or if there was a significant concern led to this being necessary.

We found most of the ward areas to be open and available to patients. The

courtyard was locked on the day of our visit due to building work taking place in the area. The acting ward manager told us this was due to be completed within the next three weeks and then this would be open and accessible to patients. Patients confirmed that this was usually open and they raised no concerns regarding accessing fresh air. In the interim, patients were supported to access another garden off the ward supervised by staff. The hospital was non-smoking.

Staff told us that community meetings were to take place weekly on the ward for patients to attend. We found the last meeting took place on 6 February 2017. Staff agreed that meetings had not been held weekly recently and they expressed a commitment to improve this.

We found that patients were supported in understanding their section 132 rights. Patients were read their rights on admission and these were repeated as identified in the patients care plans.

Carer involvement meetings took place at the Humber Centre bi-monthly. Staff told us these meetings were used to support carers and also involve carers in new policies being introduced or updated. These meetings were chaired by the security lead at the Humber Centre.

Assessment, transport and admission to hospital:

We found detention documents were available for scrutiny for the three records reviewed. We found there was a checklist in place completed by the mental health legislation department to scrutinise section paperwork. For one patient we found no form completed for the authority for transfer from one hospital to another under different managers'. For another patient we were unable to find a copy of the Approved Mental Health Professional (AMHP) report on file.

Admissions were from other hospital settings. Staff on the ward told us that admissions were usually patients with treatment resistant conditions, who were transferred from other wards, where they required a slow stream, low secure setting.

Additional considerations for specific patients:

Not covered on the day of the visit.

Care, support and treatment in hospital:

Staff told us patients were all registered with the general practitioner (GP) service provided at the Humber Centre. The Humber Centre had set up a health hub which has two general nurses, a GP and a dual trained nurse. The health hub undertook the annual physical health checks of patients, blood tests, made specialist referrals and undertook Clozapine monitoring.

Patients on the ward were in the process of having their annual physical health checks. Staff told us all patients have a physical health assessment on admission

and then these would be repeated annually every March.

Patients appeared to have some activities available daily. On the day of our visit the band 6 nurse told us there was a book club, computer session and an 'eat well' group being held and that these sessions were led by nurses.

Staff told us there was no occupational therapy provision on a Wednesday. There were plans for this to be covered now a new occupational therapist had started who started on the day of our visit. We were also told there were plans for the occupational therapist to work out of hours to provide activities in an evening.

On the three patients' records we reviewed, all had a care plans in place which were individualised. Care plans were signed by patients and copies of care plans offered and this was documented. We found an area on the care plans where patients' views could be added if they disagreed with the care plan or had other views.

For one patient we found there was a care plan in place which was very detailed and individualised but there was no record of patient involvement with the care plan. The band 6 nurse was aware of this and had picked this up through audit. They showed us evidence of them emailing the patients named nurse to address this.

Patients had risk assessments in place on the three records reviewed, which were detailed and incorporated a risk management plan.

We found patients had a multi-disciplinary team meeting at least four weekly which they were invited to attend. The minutes of these meetings were detailed and covered all aspects of the patients care and allowed for the patients views to be documented on this record.

On the three records reviewed we found there were assessments of capacity to consent to treatment completed. The date of these assessments were all on the same date and did not link with when the patients T2 certificate had been completed. For example for two patients they had a T2 certificate completed on 4 October 2016 but the section 58 record of assessment of the capacity to consent to treatment was dated 18 November 2016 which was over a month later.

We found another patient was treated under the authority of a T3 certificate. A section 61 report had been completed on 6 October 2016 and the record of the assessment of the patient's capacity to consent to treatment was on 18 November 2016.

We found the previous T3 certificate was with the patient's medication chart and not the most up to date T3 certificate. Ward staff told us that the mental health legislation team upload up to date T3 certificates to the electronic recording system when received. However, there was no system in place which prompted ward staff to be aware it had been uploaded so that this could be put with the patients current medication chart and the old one removed.

We viewed a sample of long term segregation (LTS) records for the patient being

nursed in LTS. We found the LTS records we reviewed to generally be in line with the Code of Practice. We found on the sample of time we viewed that the approved clinicians record on the weekend periods to be unclear. For example the approved clinician had written a note on the Monday following the weekend to give an overview of the weekend, but it was unclear how the patient was reviewed, at what times and the particular issues on that day. A second example for another weekend was an that an approved clinician had written a record on the Sunday about formally reviewing the patient in person on the Saturday, but it was unclear if they had reviewed the patient on the Sunday as the record did not reflect this other then it being entered on the day.

We viewed two episodes of seclusion which had taken place with the same patient on another ward due to the seclusion room being used for the LTS of another patient on the ward. We found the seclusion records to be generally in line with the Code of Practice. However, we found that a couple of nursing reviews were late. Staff told us this may be because the nurses had entered the review onto the system later, but not documented the time on the record that the nursing review had taken place.

Leaving hospital:

We reviewed all the section 17 leave forms for all the patients on the ward. For the three patients who we reviewed, we found all had section 17 leave in place.

We found that leave was authorised through a standardised system, authorised on the basis of risk assessment and appropriately recorded. Section 17 leave included specific conditions where required and patients received copies of their leave.

We were not able to see a record of whether patients, carers or relevant others had received a copy of the leave and there was no space on the form for staff to indicate this. There were old copies of section 17 leave on the patients' files we reviewed which were not struck through or cancelled.

Staff told us that discharges from the ward were to a variety of places. Some patients were discharged from the ward straight into the community. We were told some patients are transferred to a community unit within the trust to reintegrate into the community and others step down to open or locked rehabilitation wards.

Professional responsibilities:

There was evidence of tribunals and hospital manager's hearings taking place.

The trust had a checklist to support that the correct receipt of detention documentation was followed and this was then scrutinised by the MHA legislation department.

Other areas:

No other areas to report on the day of the visit.

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**	**CoP Ref:** Chapter 8

We found:

We found patients were not able to have personal access to the internet on the ward. Staff told us that patients can access internet off the ward on the patient computer or if they have a phone that is internet enabled whilst on leave.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraphs:

> "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 patients human rights.
>
> "8.16 Communication with family and friends is integral to a patients care and hospitals should make every effort to support the patient in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media. Providers should, however, provide patients access to a coin or card operated phone.
>
> "8.21 Managers should develop policies on access by patients to e-mail and internet facilities by means of the hospitals IT infrastructure. This guidance should cover the availability of such facilities and rules prohibiting access to illegal or what would otherwise be considered inappropriate material, e.g. pornography, gambling or websites promoting violence, abuse or hate. Additionally, the guidance should cover the appropriate use of social media such as Skype. A blanket restriction on access to the internet could breach article 8 if it cannot be justified as necessary and proportionate. For further details about not applying blanket restrictions see paragraphs 8.5 – 8.9."

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 1

We found:

Staff told us that community meetings were to take place weekly on the ward for patients to attend. We found the last meeting took place on 6 February 2017, staff agreed that meetings had not been held weekly recently and that there was a focus to improve this.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"1.10 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them."

Domain 2 **Assessment, transport and admission to hospital**	**CoP Ref:** Chapter 14

We found:

For one patient we found no authority for transfer from one hospital to another under different managers' form completed. For another patient we were unable to find a copy of the Approved Mental Health Professional (AMHP) report on file.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"14.93 The AMHP should provide an outline report for the hospital at the time the patients first admitted or detained, giving reasons for the application and any practical matters about the patient's circumstances which the hospital should know. Where possible, the report should include the name and telephone number of the AMHP or care coordinator who can give further information. Local authorities should use a standard form on which AMHPs can make this outline report."

Domain 2 Care, support and treatment in hospital	MHA section: 58 CoP Ref: Chapter 25

We found:

On the three records reviewed we found there were assessments of capacity to consent to treatment completed. The date of these assessments was all on the same date and did not link with when the patients T2 certificate had been completed. For example for two patients they had a T2 certificate completed on 4 October 2016 but the section 58 record of assessment of the capacity to consent to treatment was dated 18 November 2016 which was over a month later. We found another patient was treated under the authority of a T3 certificate. A section 61 report was completed on 6 October 2016 and the record of the assessment of the patient's capacity to consent to treatment was 18 November 2016. We found the previous T3 certificate was with the patient's medication chart and not the most up to date T3 certificate. Ward staff told us that the mental health legislation team upload up to date T3 certificates to the electronic recording system but there was no system in place which prompted ward staff to be aware it had been uploaded so that this could be put with the patients medication chart and the old one removed.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraphs:

"25.17 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 the treatment. A record of their discussion with the patient including any capacity assessment should be made in the patient's notes as normal.

"25.86 Hospital managers should make sure that arrangements are in place so that certificates which no longer authorise treatment (or particular treatments) are clearly marked as such, as are all copies of those certificates kept with the patient's notes and medication chart."

Domain 2 Care, support and treatment in hospital	CoP Ref: Chapter 26

We found:

We viewed a sample of long term segregation (LTS) records for the patient being nursed in LTS. We found the LTS records we viewed to generally be in line with the Code of Practice. We found on the sample of time we viewed that the approved clinicians record on the weekend periods to be unclear. For example the approved clinician had written a note on the Monday following the weekend to give an overview of the weekend but it was unclear how the patient was reviewed, at what times and the particular issues on

that day. A second example for another weekend was an approved clinician had written a record on the Sunday about formally reviewing the patient in person on the Saturday, but it was unclear if they had reviewed the patient on the Sunday, as the record did not reflect this other then it being entered on the day.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"26.155 The patient's situation should be formally reviewed by an approved clinician who may or may not be a doctor at least once in any 24-hour period and at least weekly by the full MDT. The composition of the MDT should be decided by the provider's policy on long-term segregation, but should include the patient's responsible clinician and an IMHA where appropriate. Provider's policies should provide for periodic reviews by a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome)."

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 26

We found:

We viewed two episodes of seclusion which had taken place with the same patient on another ward due to the seclusion room being used for the LTS of another patient on the ward. We found the seclusion records to be generally in line with the Code of Practice. However, we found that a couple of nursing reviews were late.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"26.134 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 involved directly in the decision to seclude."

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

We found:

We were not able to see record of whether patients carers or relevant others had received a copy of the leave and there was no space on the form for staff to indicate this. There were old copies of section 17 leave on the patients' files we reviewed which were not struck through or cancelled.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

> "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	E
Issue:	
Would like to see a doctor to discuss some worries he has about his spine. Please meet with the patient to discuss and update us of the outcome.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
Author	Care Quality Commission
Audience	Providers
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