

Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Willerby Hill
Ward(s) visited:	Greentrees Lodge (Medium Secure) and South West Lodge (Low Secure)
Ward types(s):	Secure Ward
Type of visit:	Unannounced
Visit date:	2 August 2017
Visit reference:	37973
Date of issue:	10 August 2017
Date Provider Action Statement to be returned to CQC:	31 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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	
<input type="checkbox"/>	Purpose, respect, participation and least restriction	<input checked="" type="checkbox"/>	Protecting patients' rights and autonomy	<input type="checkbox"/>	Purpose, respect, participation and least restriction
<input type="checkbox"/>	Patients admitted from the community (civil powers)	<input checked="" type="checkbox"/>	Assessment, transport and admission to hospital	<input type="checkbox"/>	Discharge from hospital, CTO conditions and info about rights
<input type="checkbox"/>	Patients subject to criminal proceedings	<input type="checkbox"/>	Additional considerations for specific patients	<input type="checkbox"/>	Consent to treatment
<input type="checkbox"/>	Patients detained when already in hospital	<input checked="" type="checkbox"/>	Care, support and treatment in hospital	<input type="checkbox"/>	Review, recall to hospital and discharge
<input type="checkbox"/>	Police detained using police powers	<input checked="" type="checkbox"/>	Leaving hospital		
		<input checked="" type="checkbox"/>	Professional responsibilities		

Findings and areas for your action statement

Overall findings

Introduction:

Greentrees Lodge is a long stay medium secure unit for male patients. It had 16 beds and there were 14 patients on the day of our visit, all detained under the Mental Health Act (MHA).

South West Lodge is a low secure unit for male patients. It had four beds. There were three patients allocated to the ward on the day of our visit, all detained under the MHA. The unit had no staff but staff visited from the wards in which patients had stepped down from at fixed times throughout the day. The frequency of visits was decided via a risk assessment and through the patients' multi-disciplinary team (MDT).

All patients had access to their own rooms with en suite toilet and wet room style shower facilities. The wards had access to garden areas which patients could easily access.

There was a seclusion suite located on Greentrees but we were told by staff this was not used and had been decommissioned.

The nurse in charge of Greentrees told us that baseline staffing for the ward was five staff to include two qualified nurses and three healthcare assistants. They told us shift patterns were long days on the ward. The night shift baseline staffing was one qualified nurse and two healthcare assistants.

On the day of our visit there was one qualified nurse on the ward who was also nurse in charge and three healthcare assistants. The ward manager was on annual leave and the charge nurse was on a day off. Therefore the ward was running under the required staffing levels. Staff told us the ward regularly ran with only one qualified nurse on a day shift.

The ward received input from a full time occupational therapist and one band four and one band three activity coordinators. The ward had one consultant psychiatrist who acted as responsible clinician (RC) for the patients on Greentrees Lodge and one patient on South West Lodge.

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 nurse in charge and later by the service manager.

We met with four patients in private, we met with other patients informally and some

patients declined to meet with us.

We interviewed the nurse in charge of the ward. A healthcare assistant gave a tour of South West Lodge and Greentrees Lodge. We reviewed three patients' electronic records; two patients from Greentrees Lodge and one patient from South West Lodge.

We gave verbal feedback to the service manager and a deputy charge nurse from another ward at the end of our visit.

What people told us:

Patients spoke positively about staff "staff are alright, I have a good named nurse and can go to staff if I am worried", "staff are helpful", "the staff are pretty good" and "staff are very pleasant". Patients we met told us they felt safe on the ward.

Patients we met told us they could access the kitchen to make their own hot and cold drinks. We were also told they could access the garden when they wished to day or night and we observed this taking place.

Both patients and staff did make reference to a shortage of staff. Some patients told us that due to staffing shortages this could impact on them taking their section 17 leave.

Staff spoke positively about the ward. Staff raised no concerns about the ward environment.

Past actions identified:

The previous MHA monitoring visit was on 8 December 2015. The following issues were identified:

- There had been a significant reduction in the availability of activities due to staffing constraints and the loss of the activities coordinator post.

This issue was partially resolved. Greentrees Lodge had recently recruited an Occupational Therapist, and two activities coordinators to the ward. However, staffing constraints was an issue highlighted by both patients and staff on the day of our visit.

- Out of date section 17 leave forms remained on patients files and were not scored out. This could lead to mistakes being made about leave.

This issue remained.

- On some files old T2s or T3s had not been removed or scored through to show they were no longer in use. One patient's medication card did not have the T3 attached to it.

This issue was resolved on the day of our visit.

- One patient had been detained on section 3 when his detention under section 37/41 was terminated by the Ministry of Justice due to his fitness to plead. The timeline of events was not clear in the notes and staff could not explain what had happened. However the RC was able to clarify the situation. There was neither an outline nor a full approved mental health professional (AMHP) report on the file.

This was not an issue identified on the day of our visit.

- No record that the patient understood their rights when given information under section 132. There was no record that they had been informed of the role of the independent mental health advocate (IMHA). There was nowhere on the rights form in use to put this information and no record in daily notes about the content of the section 132 discussion with the patient.

These issues had been resolved on the records reviewed on the day of our visit. However, we did raise a further issue with section 132 rights for one patient record we viewed.

- Patients from out of the local geographical area but within the forensic regional services had difficulty at times in accessing the full range of GP services. Although a GP and a practice nurse held regular clinics in the lodge, patients were not registered with their practice. If a patient required routine surgery or other services, they could be registered temporarily with the GP practice in Hull that provided a service to the homeless population. Staff told us that discussions to try to resolve this issue were ongoing with the clinical commissioning group (CCG). This was a longstanding issue that was not conducive to meeting patients' physical healthcare needs with consistency. We were not aware of any reason why patients who had been resident in the Humber area for many years by virtue of their detention should be disadvantaged in this way.

This issue had been resolved.

Domain areas

Protecting patients' rights and autonomy:

We reviewed three patients' records to find out whether they had been informed of their legal position and rights as required under the MHA section 132. We found patients had been informed of their legal position and section 132 rights. However, for one patient we found that they were last informed of their section 132 rights in April 2017 and their care plan stated that their section 132 rights should be revisited on a three monthly basis, this had not yet taken place. For one patient we found their section 132 rights form had not been fully completed so it was unclear what information they had been provided about the independent mental health advocate (IMHA) service.

On Greentrees Lodge We saw relevant information on display around the ward including information about the Care Quality Commission (CQC) and how to complain. However, we did not see any information on display to inform patients on how to contact the IMHA service.

On South West Lodge we did not see any information on display for patients about how to contact the CQC, how to complain or about the IMHA service.

The nurse in charge told us there was an IMHA service available to patients. The service manager confirmed that patients lacking capacity to instruct an IMHA were automatically referred to the IMHA service. Staff told us the IMHA visited the ward weekly and met with patients individually. Patients were also supported at care programme approach meetings by the IMHA if they chose to be. Staff told us there was timely access to the IMHA service and raised no concerns.

We found patients on Greentrees Lodge were not able to access a mobile phone on or off the unit. However the nurse in charge told us that if a patient requested access to their mobile phone on section 17 leave this would be considered and risk assessed. All patients on South West Lodge could have access to their mobile phones on and off the ward if they requested. There was a payphone located within a room for privacy if patients wished to make/receive telephone calls. Staff told us patients could request to use the staff phone to make private calls to solicitors, IMHA and CQC.

Patients had personal access to the internet on both wards and were risk assessed and care planned where required regarding their internet access. Computers were available on both wards. One patient told us they used the internet to Skype call their family members. They told us their care plan recently changed so that they could do this unsupervised.

Patients were able to make their own hot drinks and cold drinks on both wards without staff support. On South West Lodge patients had access to kitchen facilities and were expected to self-cater.

Patients on South West Lodge had their own fob access to allow easy access to and from the ward. The ward was located within a secure fence and therefore if patients on this ward wished to leave the grounds they would need to pass through reception and show their section 17 leave forms to be able to do this.

Patients we met throughout our visit did not raise any concerns about their bedroom areas. Patients were able to access their own bedrooms with their own individual fob access.

Patients on both wards were able to access garden areas unsupervised day or night.

Patients on both wards had access to a communal lounge area with a television. The nurse in charge and service manager told us that community meetings should take place weekly to allow patients to raise any issues. These meetings had not taken place since January 2017. The service manager told us this would be priority and re commenced.

Assessment, transport and admission to hospital:

We found for two out of the three patients records we reviewed detention documents were available for scrutiny and appeared in order. Staff were unable to locate a copy of one patient's hospital order with restrictions therefore we were unable to check that their detention documentation was in order.

Patients were usually transferred to Greentrees Lodge and South West Lodge from the Humber Centre. Admissions to Greentrees Lodge were also taken from high secure settings. We were told admissions were planned and that patients from high secure settings often came initially on trial leave to Greentrees Lodge.

The nurse in charge told us that all staff received mandatory training in the Mental Capacity Act and MHA training.

Additional considerations for specific patients:

This area was not covered on the day of our visit.

Care, support and treatment in hospital:

We found the RC had made a record of the patients' capacity to consent to treatment either at first or most recent administration of treatment for mental disorder in the patients' electronic records we viewed. We found second opinion appointed doctor (SOAD) requests had been made where appropriate and section 61 reports completed.

The occupational therapist told us that there were certain activities which were run throughout the week for patients these included baking, woodwork, craft group and a weekly community group where patients would be supported to go to local places of interest. Nursing staff told us they provided patients with activities in addition to this

such as bingo, crosswords and supporting patients on leave. Staff told us they felt that there were more activities available now staff had started on the ward to support in this. Patients gave us mixed feedback about activities, some feeling there was enough to do and others saying they were bored at times particularly at weekends. On the day of our visit we observed patients baking in the afternoon.

We observed positive staff and patient interaction throughout the day.

Staff told us that patients were registered with the primary care team based within the health hub which included access to a general practitioner (GP). The nurse in charge told us where patients had more complex physical healthcare needs and required district nursing input they were registered with a local GP surgery. There were no concerns raised by staff or patients about access to this service.

The nurse in charge told us that patients received an annual physical health check; however on the three patients records viewed we were unable to find a record of this.

We viewed the care plans for three patients. Care plans reflected the patients care and treatment. We found care plans to be written in a nursing led way rather than collaboratively with the patient. On all three patients care plans viewed it was unclear to see the level of participation the patient had in their care plan, whether they agreed/disagreed and whether they were offered a copy of their care plan. For two patients their care plans had been recently reviewed, however, one patients care plans had not been reviewed since April 2016. Staff told us the expectation was for care plans to be reviewed as a minimum monthly or if care needs changed.

We found patients had risk assessments in place and risk management plans.

Leaving hospital:

In the three patient records we reviewed, all patients had some section 17 leave in place. We found leave was authorised through a standardised system and appropriately recorded including specified conditions. Ministry of Justice approval letters for section 17 leave were kept with the section 17 leave authorisations.

We found that some out of date section 17 leave authorisation forms remained on file on the patient's records we viewed which could have caused confusion to staff.

We viewed the multi-disciplinary team meeting minutes for the three patient's records. We reviewed and found them not to have recorded who attended the meeting and various sections of the meeting left blank. It was not always clear if section 17 leave had been reviewed in some of the minutes or how leave was being authorised on the basis of a risk assessment within the meeting. Staff told us it was mainly in those meetings section 17 leave was discussed and approved.

Patients did raise staffing shortages as having an implication on their section 17 leave at times. We asked the service manager to provide us with information about

cancelled section leave for June and July 2017. We found in June 2017 that 15 patients section 17 leaves was cancelled due to staffing shortages and only three were rearranged to take place on a different day. In July 2017 we found four patients section 17 leaves had been cancelled but had been rearranged for alternative days. The service manager told us that staff sickness levels had been particularly high which had some impact on staffing shortages. We were very concerned to hear this and the impact this was having on the patients' experience.

The nurse in charge told us that patients were usually transferred from the ward to low secure settings. Some patients on South West Lodge were discharged into the community.

Professional responsibilities:

The nurse in charge told us that all nursing staff was trained in how to admit patients onto the ward and check the relevant detention paperwork. The MHA administration department completed the scrutiny of the detention records.

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

Staff told us that lessons learnt were usually shared through management disseminating this information to staff and through emails to staff.

The nurse in charge told us that staff was skilled in supporting patients who presented with disturbed behaviour through the use of de-escalation. The nurse in charge told us they were not aware of any recent time when restraint had been required on the ward.

Other areas:

We found bedroom 14 which was empty smelt strongly of drainage and the en suite floor was marked and rusty around the drain. We found one bathroom floor to be marked. Issues around en suites were raised on our last visit as detailed above. The service manager told us work was due to commence on bedroom 14 and to look at the en suite floors.

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:	
<p>We reviewed three patients' records to find out whether they had been informed of their legal position and rights as required under the MHA section 132. We found patients had been informed of their legal position and section 132 rights. However, for one patient we found that they were last informed of their section 132 rights in April 2017 and their care plan stated that their section 132 rights should be revisited on a three monthly basis, this had not yet taken place. For one patient we found their section 132 rights form had not been fully completed so it was unclear what information they had been provided about the independent mental health advocate (IMHA) service.</p>	
Your action statement should address:	
<p>How you will demonstrate adherence with the following Code of Practice paragraph 4.28:</p> <p>“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).”</p>	

We found:

On Greentrees Lodge We saw relevant information on display around the ward including information about the Care Quality Commission (CQC) and how to Complain. However, we did not see any information on display to inform patients on how to contact the IMHA service.

On South West Lodge we did not see any information on display for patients about how to contact the CQC, how to complain or about the IMHA service.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs at 4.56:

“Information about how to make a complaint to the service commissioner, CQC or Parliamentary and Health Ombudsman should also be readily available.”

and 6.15

“Certain people have a duty to take whatever steps are practicable to ensure that patients understand that help is available to them from IMHA services and how they can obtain help, as set out in the following table. This must include giving the relevant information both orally and in writing.”

Domain 2
Protecting patients' rights and autonomy

CoP Ref: Chapter 1

We found:

The nurse in charge and service manager told us that community meetings should take place weekly to allow patients to raise any issues. These meetings had not taken place since January 2017. The service manager told us this would be priority and re commenced.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs at 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 37

We found:

We found for two out of the three patients records we reviewed detention documents were available for scrutiny and appeared in order. Staff were unable to locate a copy of one patient's hospital order with restrictions. We were therefore unable to check that their detention documentation was in order.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs at 37.12:

“It is the hospital manager's responsibility to ensure that the authority for detaining patients is valid and that any relevant admission documents are in order. A copy of the report made by the approved mental health professional (AMHP) should also be obtained. Hospital managers should have a clear system in place for notifying local authorities when the patient is a child or young person. For guidance on the receipt, scrutiny and rectification of documents.”

We found:

The nurse in charge told us that patients received an annual physical health check; however on the three patients records viewed we were unable to find a record of this.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs at 1.17:

“Physical healthcare needs should be assessed and addressed including promotion of healthy living and steps taken to reduce any potential side effects associated with treatments.”

and 24.57

“Commissioners and providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. The physical needs of patients should be assessed routinely alongside their psychological needs. Commissioners need to ensure that long term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral.”

We found:

We viewed the care plans for three patients. Care plans reflected the patients care and treatment. We found care plans to be written in a nursing led way rather than collaboratively with the patient. On all three patients care plans viewed it was unclear to see the level of participation the patient had in their care plan, whether they agreed/disagreed and whether they were offered a copy of their care plan. For two patients their care plans had been recently reviewed, however, one patients care plans had not been reviewed since April 2016. Staff told us the expectation was for care plans to be reviewed as a minimum monthly or if care needs changed.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs at 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.”

We found:

We found that some out of date section 17 leave authorisation forms remained on file on the patient's records we viewed which could have caused confusion to staff.

We viewed the multi-disciplinary team meeting minutes for the three patient's records we reviewed and found them not to have recorded who attended the meeting and various sections of the meeting left blank. It was not always clear if section 17 leave had been reviewed in some of the minutes or how leave was being authorised on the basis of a risk assessment within the meeting. Staff told us it was mainly in those meetings section 17 leave was discussed and approved.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice paragraphs at 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)).”

We found:

Patients did raise staffing shortages as having an implication on their section 17 leave at times. We asked the service manager to provide us with information about cancelled section leave for June and July 2017. We found in June 2017 that 15 patients section 17 leaves was cancelled due to staffing shortages and only three were rearranged to take place on a different day. In July 2017 we found four patients section 17 leaves had been cancelled but had been rearranged for alternative days. The service manager told us that staff sickness levels had been particularly high which had some impact on staffing shortages. We were very concerned to hear this and the impact this was having on the patients' experience.

Your action statement should address:

The action the trust will take to ensure there are sufficient numbers of staff available on this ward to meet the needs of this patient group in accordance with paragraph 8.52 of the Code of Practice which states:

“Managers of hospitals offering accommodation with enhanced levels of security should ensure that: accommodation specifically designated for this purpose has adequate staffing levels.”

And paragraph 8.59 which states:

“In conjunction with clinical staff, managers should regularly review and evaluate the mix of patients (there may, for example, be some patients who ought to be in a more secure environment), staffing levels and the skills mix and training needs of staff.”

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	A
Issue:	
Patient A told us they would like more freedom in the kitchen to be able to make their own cereals when they wished. They told us the cereals were locked away and would like them to be available.	
We asked staff to meet with the patient to discuss this, please update us of the outcome.	

Patient reference	D
Issue:	
Patient D told us they requested their meal choice from the menu the day before which they had no concern about. However, told us staff used to photocopy their choices so that on the following day they could remember what they had chosen. Patient D explained they found this very helpful and wondered if it was possible for staff to do this again.	
We asked staff to meet with this patient and explore this, please update us of the outcome.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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