# Mental Health Act 1983 monitoring visit

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| **Provider:** | Humber NHS Foundation Trust |
| **Nominated Individual:** | Jules Williams |
| **Region:** | North |
| **Location name:** | Westlands |
| **Location address:** | Wheeler Street, Anlaby Road, Hull, Humberside, HU3 5QE |
| **Ward(s) visited:** | Westlands |
| **Ward type(s):** | Acute admission |
| **Type of visit:** | Unannounced |
| **Visit date:** | 3 November 2015 |
| **Visit reference:** | 35130 |
| **Date of issue:** | 13 November 2015 |
| **Date Provider Action Statement to be returned to CQC:** | 3 December 2015 |

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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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

Westlands is an assessment and treatment unit for 18 female patients.
On the day of our visit 17 beds were in use whilst improvement works were under way to change bathroom taps to fittings that were anti-ligature. Two bedrooms were en-suite and there were shared toilet and bathroom facilities for use by other patients.

There were 17 female patients, eight of whom were detained. A ninth patient who was subject to a community treatment order had been recalled to hospital but agreed to remain on a voluntary basis.
There were five staff on duty plus the manager and deputy. Two of the five staff were registered nurses.

The unit was on two levels. Downstairs there were two separate lounge areas, one with a dining area, a quiet room, a seclusion suite, the nursing office, an interview room, a clinic room and some staff offices. There was also one patient bedroom. The door to the garden area with a smoking shelter was open. On the first floor there were the remaining bedrooms, bathing and toilet facilities and a small lounge.

**How we completed this review:**

We visited with an expert by experience who had used mental health services elsewhere. We met with staff and looked around the unit. We spoke with patients informally and with four detained patients and one informal patient in private. We attended the weekly community meeting, sat in on part of a recovery skills session and looked at seclusion records. We did not look around the seclusion suite as it was in use.

We looked at five patient records.

**What people told us:**

Patients expressed a range of views about their care. Some said that they could talk to staff.

“They are caring towards me. I’ve had four one-to-ones today, most I’ve ever had, but they know when I am getting angry and upset and they know how to calm me down.”

“I feel unwelcome here. I don’t feel like anyone cares. I sit here day after day doing nothing. I don’t get asked to join in activities.”

“I avoid doctors and staff as much as possible because I know I am a target and I know they have the power to section me so I keep quiet but I am ignored anyway.”

“Sometimes there are no staff available for activities when I feel like doing something.”

“I am happy to take medication if it keeps me well.”

“I don’t feel safe because they let you down all the time.....they just say no for my leave. They don’t say why so it’s not worth complaining about.”

“We have bank staff male and female mainly on night shifts. I don’t mind if they are regulars but if I don’t recognise them and they are men I feel scared and vulnerable.”

“They have reduced our choice at mealtimes and I don’t know why.”

Staff told us that it had been a difficult year. There had been four patient deaths, one just after discharge, which had impacted heavily on staff confidence. In relation to the deaths one patient was detained and three were informal. Staff were preparing for the inquests. Changes had been made to bathroom fitments as a result of one death.

The recently appointed manager said that communication and supervision had been identified as issues that needed to improve. They had introduced compulsory supervision for all staff and had reinforced to staff their keyworker responsibilities throughout a patient’s stay. Formulation meetings for each patient between psychology and keyworker had proved useful in care planning.

The next ligature risk audit was booked for 9 November with the assistant director of nursing.

The manager told us that they hoped to review staffing levels across three shifts as they only had one registered nurse and three healthcare workers on nights. Staff thought this was not safe given how busy nights were.

**Past actions identified:**

On our last visit on 6 November 2014 we raised several concerns.
The ward was kept locked and all patients, including informal patients, had to ask staff before being allowed to leave the ward. There was little evidence of the patients’ participation in the formulation of their care plans in the files we reviewed.
Patients’ bedrooms were kept locked and patients did not have door keys.
Patients did not have a lockable space within their bedroom.
We asked what action the trust would take to provide a less restrictive environment and how the trust would improve patients’ participation in the development of their care plans.

These concerns were still present at this visit and a further action has been identified.

On our last visit we found that there were inconsistencies in the section 132 process and documentation. This concern had been addressed in the files reviewed.
On our last visit we found copies of section 17 leave forms remained in the patients' files without being marked as cancelled. On this visit section 17 leave forms were dated but some were not marked as cancelled. We were concerned on this visit that there were still gaps in the completion of section 17 forms relating to lack of evidence that copies were given to patients and others involved in the patients' care.
On our last visit there were inconsistencies in the entries made by the responsible clinician (RC) in the clinical notes regarding the discussion with patients to assess their capacity to consent to further treatment. We found no evidence of a discussion between the RC and one patient who would require a T2 or T3 two days after our visit despite reassurances that the discussion had taken place.

## Domain areas

**Purpose, respect, participation and least restriction:**

We found that given the size of the building on two separate floors it was difficult with current staffing levels to ensure staff availability in all areas to meet the needs of 18 patients.

We found that staff were not always available to address patient need. We had difficulty in finding staff to attend to a patient who was clearly not well in the patient lounge. We did not find that staff encouraged patients to join in activities or ensured that patients were aware that lunch was served. We were concerned that one patient had an eating problem but told us that they did not eat meals on the ward. We did not establish how this was being addressed.

On arrival in the car park we saw one patient standing on a picnic table in the garden and shouting and swearing profusely in all directions. Staff did not come into the garden to assist her. We raised this immediately with staff. One patient told us later that she had observed this behaviour and felt frightened for her own safety. When we were looking around the ward later that day the same patient was standing on the table in the garden. We asked staff to address this for her safety so that she did not come to harm.

We observed that staff involved in the recovery skills session treated patients who joined in with respect and dignity. We did not have much opportunity to observe other staff interaction with patients.

There was an activity programme in place. A 'You Said – We Did' board displayed in the reception area showed action taken in response to patient comments. A discharge tree in the main patients' area had been destroyed by an unsettled patient. There was a board displaying photos and roles of all staff.

We attended the community meeting. We found that patients raised a number of issues that staff identified as personal to the patient for discussion one to one later. We were concerned to establish whether these issues would be followed up as some patients told us that this had not happened. In the meeting patients said they would like to create some artwork such as mosaics to brighten up rooms especially the one used for children who visit. Patients also asked if a mobile hairdresser could visit the unit.

In the previous meeting patients had said when the ward was busy there were no staff to let them into their bedrooms or the laundry. Staff replied that they would respond as soon as possible. The issue that patients could not access their rooms was raised on our last visit, and we were concerned that patients could feel unsafe when the ward was busy. Bedrooms might be a safe place for them to use.
We did not find evidence that patients had been given copies of their care plans although there was a box to tick on the recovery plan to show they had received the care plan. Some patients told us that they were not involved in their care and that their treatment had not been explained to them. Two patients said they did not know where the facilities such as the laundry room were. Patients said they could not always identify staff because their name badges were not visible as they were worn low down at waist level.

Most patients were unhappy about the food on the unit. They said the options to choose from had been reduced and the food was unappetising.

**Admission to the ward:**

We looked at the mental health act documents for four detained patients and one informal patient on a community treatment order (CTO). We found appropriate systems and checklists in place to ensure that admission documents were received and appropriately scrutinised.

We found reports by approved mental health professionals (AMHPs) on all files.
We found that all patients had been given information about their rights as required by section 132 on admission and at other times. Some patients had signed to say that they understood their rights or staff noted that they had refused to sign.
We saw that there were no notice boards displaying information relating to detention and access to independent mental health advocacy (IMHA) services. Staff told us that a patient had recently destroyed the boards and that replacements had been ordered.

**Tribunals and hearings:**

The domain was not reviewed on this visit.

| **Leave of absence:** |
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| Some patients told us that they could not have section 17 leave due to staffing levels. We found that some out of date leave forms had not been deleted, although they did display start and end dates. We found that section 17 leave forms were not signed by patients. There was no evidence that copies of the leave forms had been given to patients or others such as carers who were involved in some leave arrangements. |
| **Transfers:** |
| The domain was not reviewed on this visit. |
| **Control and security:** |
| The unit used the Galatean Risk and Safety Tool (GRiST) to assess risk issues. We expressed concern that one patient scored highly on the tool but had substantial section 17 leave. Staff replied that the GRiST tool could be subjective to the assessor and that other tools might be more appropriate in this setting. In the light of recent patient deaths assessment of risk is critical. We highlighted that this needed immediate review.<br><br>Patients told us that they did not always feel safe on the unit. They could not access their rooms without staff, and yet bedrooms could be a safe place when the ward was unsettled. We had difficulty in locating staff at times during our visit, and we highlighted earlier in this report that the building was difficult for five staff to cover. |
| **Consent to treatment:** |
| We could not find on one patient's file a record of the RC's discussion with the patient about medication and assessment of their capacity to consent. The patient's treatment required authorisation under section 58 procedures two days after our visit. Staff told us that the RC had met with the patient and established that she had capacity to consent. There was no documented evidence that this had taken place. |
| **General healthcare:** |
| The domain was not reviewed on this 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**<br>Purpose, Respect, Participation, Least Restriction | **MHA section:**<br>**CoP Ref:** Chapters 1, 26 |
|---|---|

**We found:**

On arrival in the car park we saw one patient standing on a picnic table in the garden and shouting and swearing profusely in all directions. Staff did not come into the garden to assist her. We raised this immediately with staff. One patient told us later that she had observed this behaviour and felt frightened for her own safety. When we were looking around the ward later that day the same patient was standing on the table in the garden. We asked staff to address this for her safety so that she did not come to harm.

We found that staff were not always available to address patient need. We had difficulty in finding staff to attend to a patient who was clearly not well in the patient lounge. We did not find that staff encouraged patients to join in activities or ensured that patients were aware that lunch was served.

**Your action statement should address:**

What action you will take to ensure that there are sufficient staff on the unit to promote respect and dignity for all in accordance with the Code of Practice chapters 1 and 26 which state:

1.13:

“Patients and their carers should be treated with respect and dignity. Practitioners performing functions under the Act should respect the rights and dignity of patients and their carers, while also ensuring their safety and the safety of others.”

And 26.18:

“…A The care environment:

- ensuring an appropriate number and mix of staff to meet the needs of the patient population…”

| **Domain 2**<br>Purpose, Respect, Participation, Least Restriction | **MHA section:**<br>**CoP Ref:** Chapter 1 |
|---|---|

**We found:**

No evidence that patients had been given copies of their care plans although there was a box to tick on the recovery plan to show they had received the care plan. Some patients told us that they were not involved in their care and that their treatment had not been explained to them. Two patients said they did not know where the facilities such as the laundry room were. They also said they could not always identify staff because their name badges were not visible.

**Your action statement should address:**

What action you will take to ensure that patients are involved in the development of their care plans in line with the Guiding principles of the Code of Practice, which states:

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...”

And 1.8:

“A patient’s views, past and present wishes and feelings (whether expressed at the time or in advance), should be considered so far as they are reasonably ascertainable...”

| **Domain 2**<br>Purpose, Respect, Participation, Least Restriction | **MHA section:**<br>**CoP Ref:** Chapter 1 |
|---|---|

**We found:**

Patients did not have a key to their bedrooms. This was a blanket rule covering all patients rather than subject to a risk assessment. We raised this on our last visit as a restrictive practice.

In the community meetings patients had said when the ward was busy there were no staff to let them into their bedrooms or the laundry. Staff replied that they would respond as soon as possible. The issue that patients could not access their rooms was raised on our last visit. We remained concerned that patients could feel unsafe when the ward was busy. Access to bedrooms might help patients to feel safe.

**Your action statement should address:**

What action you will take to review bedroom access in line with the Code of Practice which states:-

1.5:

“Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person’s rights and freedom of action.”

And 1.6:

“Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided...”

| **Domain 2**<br>Leave of absence | **MHA section:**<br>**CoP Ref:** Chapter 27 |
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**We found:**

Some patients told us that they could not have section 17 leave due to staffing levels.

We found that some out of date leave forms had not been deleted, although they did display start and end dates.

We found that section 17 leave forms were not signed by patients.

There was no evidence that copies of the leave forms had been given to patients or others such as carers who were involved in some leave arrangements.

**Your action statement should address:**

What action you will take to audit patients' access to authorised section 17 leave. What action you will take to ensure that out of date section 17 leave forms are removed from patients' files or clearly marked as cancelled.

How the trust will ensure that staff record the patients' agreement to the leave plan and whether copies were given to patients and involved parties including carers in line with the Code of Practice which states:

> 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 any carers, professionals and other people in the community who need to know…

| **Domain 2**<br>Control and security | **MHA section:**<br>**CoP Ref:** Chapter 26 |
|---|---|

**We found:**

The unit used the Galatean Risk and Safety Tool (GRiST) to assess risk issues. We expressed concern that one patient scored highly on the tool but had substantial section 17 leave. Staff replied that the GRiST tool could be subjective to the assessor and that other tools might be more appropriate in this setting. Assessment of risk is always critical but especially so in the light of recent patient deaths. We highlighted that this needed immediate review.

Patients told us that they did not always feel safe on the unit. They could not access their rooms without staff, and yet bedrooms could be a safe place when the ward was unsettled. We had difficulty in locating staff at times during our visit, and we highlighted earlier in this report that the building was difficult for five staff to cover.

**Your action statement should address:**

What action you will take to ensure that GRiST risk assessments are reviewed and agreed by the multi-disciplinary team.

What action you will take to review the locking of bedroom doors and to ensure that all patients have a safety plan in place to help them feel safe when the ward is unsettled.

| **Domain 2**<br>Consent to treatment | **MHA section:** 58<br>**CoP Ref:** Chapter 25 |
|---|---|

**We found:**

We could not find on one patients' file a record of the RC's discussion with the patient about medication and assessment of their capacity to consent. The patient's treatment required authorisation under section 58 procedures two days after our visit. Staff told us that the RC had met with the patient and established that she had capacity to consent. There was no documented evidence that this had taken place.

**Your action statement should address:**

What action you will take to ensure that practice concerning authorisation of medication meets the requirements of the Mental Health Act and the Code of Practice which states:

25.14:

"…They cannot be given medication to which Section 58 applies unless:

- the approved clinician in charge of the treatment, or a second opinion appointed doctor (SOAD), certifies that the patient has the capacity to consent…"

And:

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.

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:**

Did not feel safe on the ward. She thought that staff let her down and that she did not always get section 17 leave. She said that staff gave her no reasons for this.

| Patient reference: | B |
|---|---|

**Issue:**

She said that she found it hard to sleep on the ward as other patients could be noisy at night. She said that sometimes staff were not available when she needed their help.

| Patient reference: | C |
|---|---|

**Issue:**

She said that she felt scared and vulnerable at night when there were male bank staff on duty whom she did not know.
She said that the staff were caring towards her and recognised when she needed extra time with staff.

| Patient reference: | H |
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**Issue:**

She said she felt unsafe on the ward. She said she was not asked to join in activities. She felt that nobody cared about her.

## Information for the reader

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