Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Maister Lodge
Ward(s) visited:	Maister Lodge
Ward types(s):	Ward for older people with mental health problems
Type of visit:	Unannounced
Visit date:	11 August 2016
Visit reference:	36504
Date of issue:	12 September 2016
Date Provider Action Statement to be returned to CQC:	30 September 2016

What is a Mental Health Act monitoring visit?

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. We do this by looking across the whole patient pathway experience from admissions to discharge – whether patients have their treatment in the community under a supervised treatment order or are detained in hospital.

Mental Health Act Reviewers do this on behalf of CQC, by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers, and they review records and documents.

This report sets out the findings from a visit to monitor the use of the Mental Health Act at the location named above. It is not a public report, but you may use it as the basis for an action statement, to set out how you will make any improvements needed to ensure compliance with the Act and its Code of Practice. You should involve patients as appropriate in developing and monitoring 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Maister Lodge was a 16 bed ward for older people of both sexes with organic illnesses leading to memory problems. On the day of the visit there were 11 patients allocated to the ward, seven males and four females. All 11 patients were detained under the Mental Health Act 1983 (MHA).

On arrival on the day of the visit the ward was staffed by two qualified nurses, one who was on preceptorship and the other the charge nurse for the ward, and five health care assistants. The late shift started on the ward at 11.30am and this was staffed by two qualified and four health care assistants. We were told at 6pm the staffing levels would drop to 1 qualified staff nurse and four health care assistants until 7.30pm. The late shift qualified nurses were the deputy charge nurse and modern matron. The night shift on the day of the visit was covered by one qualified nurse and five health care assistants. We were told there was a high use of agency and bank staff and this was reflected in the staffing rotas. We looked at the rota for one week in August and found out of that week there were six days where the ward ran understaffed, running with one staff member short. We were told the ward always ensured that there was a permanent member of staff on duty. We were told there were some night shifts where the only qualified nurse was an agency staff nurse. We were told the ward was recruiting for five band 2 health care assistants and was due to interview at the end of August 2016. We were told the ward had recruited two staff nurses who were due to start in post.

The ward had one consultant psychiatrist who acted as responsible clinician (RC) for all the patients. They were supported by two junior doctors one full and one part time who had just joined the team for four months. The ward had no occupational therapist as this member was on long term sick. The ward had access to a physiotherapist, psychologist and pharmacist.

The ward was entered through a locked door into a large atrium. On our previous visit this was a communal area for patients. This had now been changed to a male area. The female patients would walk through this area when leaving the ward but the female area of the ward was now accessed by a locked keypad from the communal area. The male and female bedroom corridors were off either side of this area and were a similar layout; however, the male patients had more space with having access to the main communal area. The female area was accessed through a locked keypad and had eight bedrooms, though we were told only seven bedrooms were used. The male bedroom area had seven bedrooms but one was a low stimulus room which had nothing in. We were told soft furnishings had been ordered for this room. All bedrooms had en suite toilet and sink. The bathrooms were located in each corridor so male and female areas were separate as in line with the Code of Practice.

We were told the locked keypad into the female area had been implemented due to risk between patients and their vulnerabilities. The access to the garden areas was restricted and doors were locked requiring patients to be escorted by staff.

How we completed this review:

We made an unannounced visit to the ward. We spent time in the female area of the ward and met informally with one female patient. We spent time in the male area of the ward and met informally with four patients. We were shown around the ward by the charge nurse. We met with three health care assistants, a junior doctor, staff nurse and modern matron. We interviewed the deputy charge nurse. We reviewed five sets of patients' records.

We provided verbal feedback at the end of the visit to the modern matron.

What people told us:

Male patients spent time in the main male lounge on the ward talking with each other. Health care assistants on male patients' one to one observations tried to encourage patients to participate in activities, which included water painting, listening to music and drawing. Female patients spent time in their rooms, in the female lounge area and on one to one observations with staff. We saw staff offering patients regular drinks and snacks and engaging with patients.

Patients we met with informally were able to engage in discussions about their interests and past but not in direct questions about their current situation.

"I have a son and a daughter."
"I like to keep busy because of my condition."
"I have a mobile phone."

Staff told us that facilitating activities and leave on the ward was a challenge due to staffing levels and the high level of clinical activity on the ward in terms of the enhanced observations. Staff told us the ward desperately needed a refurbishment to meet the needs of the patients.

Past actions identified:

The previous MHA monitoring visit was on 27 May 2015. We found concerns with:

- That the staffing level for the ward did not allow for the management of higher levels of observation and for planned provision of therapeutic activity and support for section 17 leave for the patient.

  This concern remained and has been highlighted on this visit.

- That patients did not have access to secure storage for personal items in their bedrooms. We saw personal toiletry items stored in labelled plastic boxes in a

bathroom. The observation panels in the bedroom doors were all open. Staff told us they would close them when carrying out personal care with a patient. This approach meant that other patients and visitors could see into a patient's room, even when they were in them.

This concern remained.

- That the ward environment was run down and did not comply with what is considered to be current best practice in working with patients with dementia. The lighting was poor in places and signage was not appropriate for the patient group. In places there was wallpaper peeling from the wall and the paper had been torn from the wall in other places. The rooms that were used as low stimulus environments for de-escalation of aroused patients were bare, rather than being low stimulus.

  This concern remained.

- That bedrooms in the female corridor were used for both male and female patients.

  This issue had been addressed but refurbishment was required.

- That the quality of care plans was variable and did not always reflect the involvement of the patient, when they were able, or their carers. It was not always clear which was the most up to date care plan.

  This issue remained.

Domain areas

Protecting patients' rights and autonomy:

We found evidence of patients being informed of their rights, including their right to access an independent mental health advocate (IMHA). We found one patient did not have their section 132 rights revisited since admission when they lacked capacity. Staff told us that they now automatically referred patients to an IMHA on admission when completing the section 132 rights and we were told this was recorded with the mental health legislation department. We found there was no information on display in the female area of the ward about the IMHA. We found no information on display in patient areas of how to complain. We were told there was timely access to IMHA and that the same IMHA attended the ward. We tried to contact the IMHA but found they were on annual leave. We were told two patients had recently been referred to an independent mental capacity advocate (IMCA).

We were told patients did not have community meetings. We were told there was a weekly carers' meeting held at the hospital, which was led by the deputy charge nurse and psychologist. We were told the ward had set visiting times; however, we were told these were flexible and that families could attend outside of these hours if they called first.

There were daily care review meetings. Staff told us there used to be a weekly ward review but they had found that the daily care reviews were more effective. We were told all patients' care was reviewed daily and the RC attended with any other multidisciplinary team members who were present. We were told that due to having these meetings daily that they could create more actions to complete and with staffing levels were told it could be difficult to get actions completed. We saw minutes of these meetings but some were incomplete.

We looked at all of the care plans for the patients in the five records reviewed. We found the quality of care plans to be variable. We found care plans did look at the individual needs of the patients but that it was difficult to find evidence of patient and/or family/carer involvement. It was difficult to find a record of the level of involvement of the patient and/or their families in the care review process. We found the care plans allowed staff to indicate if patients had capacity to understand the care plans. We found some of these were incomplete. For ones which said the patient did not have capacity to understand the care plan we did not find record of capacity assessments in the files to support this. Staff told us they went through care plans with family and encouraged family to be part of discharge planning.

We found the ward to be locked on the day of the visit. We were told that they did take informal patients but that this was rare. We asked if they had a sign they would put up if they had informal patients to inform them of their rights to leave the ward; we were told they did not have one.

We were told patients were allowed to have their own mobile phone on the ward and restrictions only put in place if there was a risk issue. One patient told us they had a

mobile phone. We did not find any direct access to a phone on the ward for patients and there was no personal access to the internet available on the ward for patients. We were told there was a digital reminiscence kit but that staff had not been trained on how to support patients to use this.

Each patent had their own bedroom with en suite toilet and sink. We were told patients were able to personalise their bedrooms. We found the garden access to be locked. Patients required staff to supervise them in these areas. We did not find these blanket restrictions to be individually risk assessed in line with the Code of Practice.

We found patients bedroom doors were often left open; sometimes this was to support observations. This was not an issue raised to us by patients. Staff told us it was patient choice to have their bedroom doors open.

Throughout the visit we observed positive staff and patient interaction. We observed staff finding it challenging to manage the ward with the number of staff on that day and the enhanced observations. There were few activities on offer and section 17 leave was cancelled.

Assessment, transport and admission to hospital:

Detention documents were available for scrutiny. This documentation contained the legal criteria for detention. We were not able to find a copy of an approved mental health professional (AMHP) report for one patient in the files reviewed.

Additional considerations for specific patients:

We found staff had not received updated training in the revised Code of Practice. We were told a band 6 staff nurse was due to start on the ward and had best interest assessor training. We were told they were going to be responsible for delivering training on the MHA on the ward and this would cover the Code of Practice.

We were told the psychologist had recently delivered training to staff on dementia, this included both qualified and unqualified staff.

Care, support and treatment in hospital:

We found all patients whose records were checked were being treated under the appropriate authority. We found that T2 and T3 certificates were with the medication cards when they were required. We found one patient been treated under section 62. We found a second opinion appointed doctor (SOAD) had visited the ward but we found little record of the visit. The T3 had not yet arrived on the ward. The RC had not made any record that they had, had a conversation with the patient about the result of the SOAD visit. We found the statutory consultees had not made a record in the patient's notes to say that they had had a conversation with the SOAD.

We were shown patient bedroom areas. We were told patients were able to

personalise their rooms.

The ward did not have access to seclusion facilities. We were told that the ward would use de-escalation rooms if required. We found these rooms to be empty and bare. We were told some soft furnishings for these rooms were on order. We found that the ward environment was run down and did not comply with what was considered to be current best practice in working with patients with dementia. The lighting was poor in places and signage was not appropriate for the patient group. We found male signs up in the female area of the ward. In places there was wallpaper peeling from the wall and the paper had been torn from the wall in other places. We found this on our last visit. We were told that refurbishment was due to commence this year and it had been delayed.

We were told that personal and room searches did not take place on the ward.

We were aware of several safeguarding incidents taking place on the ward between patients, patient assaulting other patients. We were shown the safeguarding log and told it would be reported on the electronic incident reporting log. Staff told us they had good links with the Humber safeguarding team and local authority. Staff told us referrals were made to the local authority when appropriate.

Staff told us that patients who were registered with GPs in the Hull area would remain with their practice. We were told patients from out of the area were registered temporarily with the local GP surgery. Staff told us this could sometimes be challenging as patients could be admitted requiring district nursing care and needed to be registered with a GP to receive this. We found the ward was responsive to a patient who had been admitted the previous evening and they registered them at the local GP and had referred them to the district nursing team.

Leaving hospital:

We were told there was a process in place for discussing section 17 leave. Staff told us this was discussed in the care review meeting with the responsible clinician. We were told the patient attended the review where possible. We found it difficult to find evidence of how leave was authorised by the RC on the basis of a risk assessment. We saw copies of leave authorisation forms; for one we found it did not stipulate whether the leave was escorted or unescorted. The leave forms and records did not record whether the patient or family member had been given a copy. We found that some had escorted leave with family written but there was no record found in the files of this been discussed with the family. There was a space for patients to sign but this was blank on all of the files reviewed. We found old section 17 leave forms on file that had not been cancelled or struck through, which could lead to confusion for staff.

On the day of our visit patients were unable to take their section 17 leave due to short staffing; looking at the rotas staffing was an issue on the ward and had implications on section 17 leave. We were told that one patient had been on leave the day before our visit.

There was evidence seen of discharge planning in the records and also involvement with family and the community mental health teams where relevant.

Professional responsibilities:

There was evidence of systems in place to scrutinise documents when patients were admitted and systems in place to remind professionals when sections were due to expire.

We were told lessons learnt were shared across the trust by a ‘blue light’ alert in an email to staff.

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 4

We found:

No information on display about how to complain in patient areas of the ward. We found no information on display about independent mental health advocacy service in the female area of the ward.

Your action statement should address:

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

"4.51 Informal patients must be allowed to leave if they wish, unless they are to be detained under the Act. Both the patient and, where appropriate, their carer and advocate should be made aware of this right with information being provided in a format and language that the patient understands. Local policies and arrangements about movement around the hospital and its grounds must be clearly explained to the patients concerned. Failure to do so could lead to a patient mistakenly believing that they are not allowed to leave hospital, which could result in an unlawful deprivation of their liberty and a breach of their human rights."

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 8

We found:

We did not find any direct access to a phone on the ward for patients.

Your action statement should address:

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

"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."

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 8

We found:

We found access to the garden areas to be locked, requiring staff to escort patients in the garden. The garden had several hazards and was not 'dementia friendly'. We did not find these blanket restrictions to be individually risk assessed in line the Code of Practice 2015 (CoP).

Your action statement should address:

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

"8.5 In this chapter the term 'blanket restrictions' refers to rules or policies that restrict a patients liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records."

Domain 2 **Care support and treatment in hospital**	**CoP Ref:** Chapter 14 and 17

We found:

We did not find a copy of the AMHP report for one patient in the five files reviewed.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (CoP) 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:** 132 **CoP Ref:** Chapter 4

We found:

For one patient they had not had their section 132 rights revisited since their admission and records indicated they lacked capacity in terms of understanding their section 132 rights.

Your action statement should address:

How you will demonstrate adherence with CoP 4.28 and 4.29 which state:

> "4.28 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).
>
> "4.29 A fresh explanation of the patients' rights should be considered in particular where… Any significant change in their treatment is being considered…"

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 1 and 8

We found:

That the staffing level for the ward did not allow for the management of higher levels of observation and for planned provision of therapeutic activity, access to fresh air and support for section 17 leave for the patients.

That there was a high use of bank and agency staff on the ward. These staff were less familiar with the needs of the patients and were less able to support a positive therapeutic environment. There were shifts that were not fully staffed running one member of staff short.

Your action statement should address:

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

> "1.15 Care, support and treatment given under the Act should be given in accordance with up-to-date national guidance and/or current best

practice from professional bodies, where this is available. Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate.

"1.16 Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate…

"8.52 Managers of hospitals offering accommodation with enhanced levels of security should ensure that:

- accommodation specifically designated for this purpose has adequate staffing levels"

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 1

We found:

That the ward environment was run down and did not comply with what was considered to be current best practice in working with patients with dementia. The lighting was poor in places and signage was not appropriate for the patient group. We found a male sign for a toilet in the female only area of the ward.

In places there was wallpaper peeling from the wall and the paper had been torn from the wall in other places. We found the garden had several hazards and therefore was locked and required patients to be escorted by staff.

The rooms that were used as low stimulus environments for the de-escalation of aroused patients were bare, rather than being low stimulus.

That patients did not have access to secure storage for personal items in their bedrooms.

Your action statement should address:

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

"1.16 Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate."

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 25

We found:

We found one patient been treated under section 62. We found a second opinion appointed doctor (SOAD) had visited the ward but we found little record of the visit. The T3 had not yet arrived on the ward. The RC had not made any record that they had had a conversation with the patient about the result of the SOAD visit. We found the statutory consultees had not made a record in the patients notes to say that they had, had a conversation with the SOAD.

Your action statement should address:

How you will demonstrate adherence with CoP 25.66 and 25.67 which states:

"25.66 It is the personal responsibility of the clinician in charge of the treatment to communicate the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD. But when a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the clinician in charge of the treatment (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person.

"25.67 Documents provided by the SOADs are a part of, and should be kept in the patients notes. The clinician in charge of the treatment should record their actions in providing patients with (or withholding) the reasons supplied by the SOAD."

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 1, 24 and 34

We found:

We found care plans did look at the individual needs of the patients but that it was difficult to find evidence of patient and or family/carer involvement. It was difficult to find a record of the level of involvement of the patient and/or their families in the care review process. We found the care plans allowed staff to indicate if patients had capacity to understand the care plans. We found some of these were incomplete for ones which said the patient did not have capacity to understand the care plan we did not find record of capacity assessments in the files to support this.

Your action statement should address:

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

"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.

"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.

"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."

Domain 2 **Considerations for specific patients**	**CoP Ref:** Chapter 1
We found:	
Staff had not received training on the revised Code of Practice (2015).	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (CoP) paragraphs: "1.21 Commissioners, providers and other relevant organisations should ensure that their staff have sufficient skills, information and knowledge about the Act and provision of services to support all their patients. There should be clear mechanisms for accessing specialist support for those with additional needs."	
Domain 2 **Leaving Hospital**	**MHA section:** 17 **CoP Ref:** Chapter 27
We found:	
We found it difficult to find evidence of how leave was authorised by the RC on the basis of a risk assessment. We saw copies of leave authorisation forms, for one we found it did not stipulate whether the leave was escorted or unescorted. The leave forms and records did not record whether the patient or family member had been given a copy. We	

found that some had escorted leave with family written but there was no record found in the files of this been discussed with the family. There was a space for patients to sign but this was blank on all of the files reviewed. We found old section 17 leave forms on file that had not been cancelled or struck through which could lead to confusion for staff.

On the day of our visit patients were unable to take their section 17 leave due to short staffing, when we looked at the rotas staffing is an issue on the ward and impacts on section 17 leave. We were told that one patient had been on leave the day before our visit.

Your action statement should address:

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

"27.16 The parameters within which this discretion may be exercised should be clearly set out by the responsible clinician, e.g. the particular places to be visited, any restrictions on the time of day the leave can take place, and any circumstances in which the leave should not go ahead.

"27.17 Responsible clinicians should regularly review any short-term leave they authorise on this basis and amend it as necessary.

"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 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, no patients raised specific issues regarding their care, treatment and human rights.

Information for the reader

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