Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated Individual:	Jules Williams
Region:	North
Location name:	Willerby Hill
Location address:	Beverley Road, Willerby, Hull, Humberside, HU19 6ED
Ward(s) visited:	Ouse
Ward type(s):	Medium secure
Type of visit:	Unannounced
Visit date:	29 June 2015
Visit reference:	34397
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Date Provider Action Statement to be returned to CQC:	11 August 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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	
☐	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:

Ouse ward is a rehabilitation ward for 14 men, in conditions of medium security. It forms part of the Humber Centre secure unit. On the day of the visit there were 12 patients allocated to the ward, all of whom were detained under the Mental Health Act (1983) (MHA).

There were two registered nurses and four health care assistants on duty, with an activity co-ordinator. A consultant psychiatrist was responsible for this ward and a low secure rehabilitation ward. He was the responsible clinician (RC) for all patients on the ward. We were told that the ward was also supported by a clinical psychologist, art therapist and clinical nurse specialist.

The ward is designed around a central area with two bedroom corridors off. Patients had access to an internal courtyard at all times, with smoking permitted for 15 minutes every hour. The courtyard contained a smoking shelter. Access to drinks was available from a flask of hot water in a lounge. This was opposite the patients' kitchen, which had been closed on safety grounds.

There was a payphone on the corridor outside of the ward office, which did not afford much privacy to the user. Staff told us that if patients wanted to make a private phone call to their solicitor or advocate, then they would be set up in a side room with a telephone, giving them more privacy.

Food was provided from a central kitchen. We were told that the same food was better in the on-site café than on the ward. We were told that a group consisting of a representative from each ward meets regularly with the catering manager and dietitian. Patients were allowed to order a take away every Friday and if the ward was celebrating a birthday or a patient moving on. The choice of menu rotated weekly.

We were told that the ward had a weekly community meeting and were shown the notes from the last meeting.

The ward uses paper records, with the MHA documentation stored in the current notes folder.

How we completed this review:

A Care Quality Commission (CQC) Mental Health Act Reviewer made an unannounced visit to the ward. We spoke informally with staff and patients and in private with three patients. We left a record of the issues which we had discussed with one patient as a letter. This was left with staff to give to the patient when it was

clinically appropriate to do so. We reviewed the case notes and detention documents of three patients. At the end of the visit we gave some informal feedback to the ward manager.

What people told us:

Staff told us that there were proposals to upgrade parts of the ward, but that there were no definitive timescales for some of the work.

Patients were generally complementary about the ward and staff and the atmosphere was relaxed. We saw examples of good interaction between the staff and patients.

Patients told us:
“The hospital is run safe, secure and adequate.”
“Over the past year I have seen evidence of the [financial] cuts.”
“I see this place as being very fair.”
“I’ve been in a few hospitals and this is one of the best that I have been to.”
“It’s quite a calm and steady ward. Every once in a while someone relapses.”
“I am cooking in the occupational therapy (OT) kitchen because the ward kitchen is out of action. It has been out of action for a while.”
“It’s a good ward, its run quite well. I like it on this ward. The nurses are good when you are not feeling so well.”
“Sometimes it’s alright, sometimes some staff talk down to you – just particular staff.”

Past actions identified:

On our last visit on 14 November 2013 we were unable to find assessments of capacity for patients in regard to treatment. In your response you provided us with copies of a section 58 consent to treatment document and a checklist. You told us that it was proposed that the form would be used by RC’s for all assessments of capacity and consent related to treatment decisions and that they would be filed with the medicine charts and T2 or T3 certificates. On this visit we were unable to find assessments of capacity for all patients we reviewed. We also noted that the section 58 consent to treatment document and checklist were not being used.

We identified that previous actions relating to the proper fitting of privacy film to windows in bedroom doors was still outstanding. On this visit we saw that the privacy film on all windows was fitted properly.

We identified that there was confusion in the language used to describe seclusion. We were unable to review seclusion records on this visit, but were assured that the staff were clear about what constituted seclusion.

We identified that patients did not have a lockable area to store belongings in their bed area when we last visited. We found that this was still the case. Your previous

action statement informed us that by 31 March 2013 “All patients will either have a lockable bedroom or lockable cabinet within it.” We were told that there had been a digital safe identified for a limited trial, but that this had not yet commenced. We were told that patients were not assessed in relation to being given the key to their bedroom.

It was unclear whether patients were being given copies of their section 17 leave forms. On this visit all of the patients we asked had been offered a copy of their leave form and the section 17 forms we reviewed showed that patients had been offered a copy.

Domain areas

Purpose, respect, participation and least restriction:

The ward was designated as being a medium secure environment. Access to and restrictions on the ward were compatible with this designation. Restrictions in access on the ward were frequently linked to the condition of the environment in particular rooms, as opposed to security or blanket restrictions on the patients.

Staff described an approach on the ward that saw the frequent use of authorised leave and this was supported by our observations. We saw positive and appropriate interactions between staff and patients during our visit. We saw an activities timetable that contained a range of on and off-ward activities and most patients that we spoke with felt that these were appropriate.

We saw evidence of patient involvement on their care plans, which were up to date and reflected patients own views where these differed from the clinical team.

Admission to the ward:

We reviewed three sets of admission and detention documents. Not all of the detention documents were available in the notes on the ward, but were quickly provided by the trust’s Mental Health Act office. All of the required documents were present and correct. One patient had detention documents in one name and renewal documents in a different name. There was no copy of the legal documents indicating the change of name.

There was evidence in the notes that patients were informed of their section 132 rights on a regular basis. All patients we spoke with were aware of the role of the independent mental health advocate (IMHA) and some patients told us that they made use of this support. They were also aware of their right to legal representation and we saw evidence of this support in the notes.

We saw posters relating to the role of the Care Quality Commission, IMHA and the local complaints procedure.

We were told that there was a weekly community meeting. We saw the notes of the meeting from the previous week, which lacked any detail.

Tribunals and hearings:

We did not review this domain on this visit.

Leave of absence:

We saw a system in place for the management of authorised leave. The forms contained details of any restrictions and were clearly filled in. All forms we reviewed showed evidence that a copy had been offered to the patient. Leave was used appropriately and took account of risks presented by the patient.

The records we reviewed showed that Ministry of Justice authorisation for leave had been applied for in respect of the one patient that required it. There was no record of a response in the notes.

Transfers:

We did not review this domain on this visit.

Control and security:

Staff told us that although they had access to seclusion facilities these were used infrequently. A review of the seclusion facilities showed that there was no independent heating in the seclusion room. Staff told us “Sometimes it’s freezing in there”. We also noted that there was an observation window into the seclusion room from the corridor. Staff told us that patients’ privacy and dignity were protected by closing the corridor when the room was in use.

We saw a consistent application of the observation policy. Observation was unobtrusive and reviewed in line with patients’ presentation.

We were told that patients were searched on return from unescorted leave. This was a condition of their leave and care planned.

No patients were subject to restrictions on communications and we felt that the level restrictions was appropriate for the type of ward.

Consent to treatment:

All treatment was given under appropriate legal authority. One patient’s T3 authorisation was in a different name to both his drug card and renewal of detention.

We found one assessment of a patient's capacity to consent to treatment in the three records that we reviewed. This was not on the form that the trust had sent to us in their previous action statement.

All T2 and T3 authorisations were properly completed, with copies with the patients' medication cards. Visits from a second opinion appointed doctor (SOAD) were arranged when necessary.

General healthcare:

Patients' general healthcare was managed with the support of a GP who attended the centre weekly. We saw evidence that physical health problems were managed by specialists when required. We were told that the ward had two physical health leads who carried out routine physiological monitoring such as weight and blood pressure.

Other areas:

The patients' kitchen on the ward had been closed on safety grounds after a cupboard had fallen from the wall. We were told that there were plans to upgrade the kitchen, but that there was no timescale associated with this. We were also told that there were no proposals to make interim repairs to the kitchen to make it available to patients again. Both staff and patients we spoke with indicated that the loss of the kitchen had potential impact on the rehabilitation of the patients.

The general feel of the ward was that the decoration was tired and needed refreshing. This was more noticeable in some areas and staff particularly pointed out the wear and scuffing of corridor doors.

We noted that some internal bathrooms and toilets were locked. These were mainly the ones which have not been refurbished and the fitments pose a ligature risk. We noted that the shower rooms that did not have windows were very hot and steamy and in need of better ventilation. One shower room contained pools of water that were unable to drain away because of the slop on the floor. Staff said that they frequently had to mop the floor of this room to manage a slip hazard.

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 1 Purpose, Respect, Participation, Least Restriction	**CoP Ref:** Chapter 1

We found:

That access to some bathrooms and toilets had been removed because they were awaiting upgrades. Some contained fitments that presented a ligature risk, others had inadequate ventilation and had pools of water on the floor that were unable to drain away.

The patients' kitchen was closed for safety reasons after a cupboard fell off the wall. We were told that the kitchen would be upgraded, but that there was no time scale.

Some areas of the ward, particularly the corridor doors, were showing signs of wear.

Your action statement should address:

What actions you will take to ensure that the facilities on the ward are suitable for the treatment of patients who have restricted liberty and in compliance with the guiding principles of the Code of Practice.

How soon the patient patient's kitchen will be available for patients' use.

Paragraph 1.16 of the Code of Practice states "Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic."

Domain 2 Consent to treatment	**MHA section:** 58 **CoP Ref:** Chapter 24

We found:

That there was inconsistent assessments of capacity and consent to treatment in respect of the patients whose records we reviewed.

That the forms for recording and monitoring capacity and consent to treatment that you provided for us with your last provider action statement were not in use.

Your action statement should address:

How you will ensure that the capacity of patients to consent to their treatment is recorded for all patients and is available for audit.

How you can assure us that the trust is monitoring its compliance with this aspect of the MHA and Mental Capacity Act (2005).

The Code of Practice states:

24.30 The Act frequently requires healthcare professionals to determine:

- whether a patient has the capacity to consent to or refuse a particular form of medical treatment, and
- if so, whether the patient does in fact consent.

The rules for answering these questions are the same as for any other patients.

24.32 When taking decisions about patients under the Act, it should be remembered that:…

- any assessment of an individual's capacity has to be made in relation to the particular decision being made – a person may, for example, have the capacity to
  consent to or refuse one form of treatment but not to another
- all assessments of an individual's capacity should be fully recorded in the patient's notes.

Domain 2 Consent to treatment	**MHA section:** 58 **CoP Ref:** Chapter 25

We found:

That one patient's T3 authorisation was in a different name to the patient's medicine card.

The patient's latest renewal of detention was in a different name to the patient's original detention order.

We were told that the patient had changed their name by Deed Poll. There was no record of this in either the medicine card or with the detention documents. The ward manager obtained a copy of the Deed from the patient during the visit and was going to insert it into the clinical record.

The T3 was three years old and issued when there was a previous RC. It is good practice for SOAD's to review treatment plans regularly. We recommend that SOAD's put a two year expiry date on T3 authorisations.

Your action statement should address:

How you will ensure that when a patient changes their name a record of this is available to the ward to ensure that treatments and detention are continued legally.

Your position in respect of the review of T3 authorisations that do not include an expiry date.

Domain 2 Purpose, Respect, Participation, Least Restriction	**CoP Ref:** Chapter 8

We found:

That there were no facilities for patients to securely store items in their room. This is an outstanding action from our last visit You told us that “All patients will either have a lockable bedroom or a lockable cabinet within it.” You told us would be completed by 31 March 2013*(sic).*

Your action statement should address:

What actions you will take to ensure that you are meeting the requirements of the Code of Practice 8.24 which states:

> Hospitals should provide adequate storage in lockable facilities (with staff override) for the clothing and other personal possessions which patients may keep with them on the ward and for the secure central storage of anything of value or items which may pose a risk to the patient or to others, eg razors. Information about arrangements for storage should be easily accessible to patients on the ward. Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so.

Domain 2 Admission to the ward	**MHA section:** 120

We found:

That not all of the required documents relating to a patients current period of detention were available on the ward, although these were available from the trust MHA office on request.

It is important that staff have access to a patient's record of detention and any associated documents in order to assure themselves that any treatment that they are giving in lawful.

Your action statement should address:

How the trust will ensure that there is a full record of the patient's current detention and any associated document immediately available for staff and other authorised people to review.

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:

The patient told us that information about him provided by a former hospital was not true. He told us that his social worker and PALS were following this up. He felt that this alleged misinformation was affecting his treatment on his current ward.

The patient told us that a member of staff had shouted at him. He said that he had made a complaint about this. We spoke with the ward manager who told us that this had been investigated by the deputy ward manager and the PALS service. Please let us know the progress and outcome of this investigation.

The patient told us that he felt that ward staff talk down to him. We raised this with the ward manager when we fed back.

Information for the reader

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