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. HU10 6ED
Ward(s) visited:	Humber Centre Forensic Unit: Darley House
Ward type(s):	Low Secure
Type of visit:	Unannounced
Visit date:	29 June 2015
Visit reference:	34329
Date of issue:	15 July 2015
Date Provider Action Statement to be returned to CQC:	04 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Darley House is an eight bedded low secure ward for male patients with long standing treatment resistant mental illness. There were eight patients at the time of our visit, all of these patients were detained under the Mental Health Act (1983) (MHA). The ward was locked.

We met with the deputy charge nurse of the ward and discussed the management of the ward and the approach taken to caring for the patient group.

We toured the unit with the deputy charge nurse. There was a TV lounge, a music lounge, a dining room, which was multi-purpose and used for a variety of activities outside of mealtimes, a multi-faith room; a large shared garden area, albeit with very little seating for patients near to the unit and a courtyard used as a smoking area. Patients had their own bedrooms. There were bathrooms, a shower and several toilets.

We were advised that staffing usually consists of five staff on the day shift and three on the night shift. As a minimum there will be one qualified nurse and four healthcare assistants on a day shift. The deputy charge nurse was supernumerary to the shift staffing.

An occupational therapist (OT) and an OT assistant were on the ward for approximately seven to ten hours a week. There was also regular psychology input to the unit.

The consultant psychiatrist was responsible clinician (RC) for all the patients on the ward and held a multidisciplinary team (MDT) ward round every week. We were told that patients were seen by the MDT every fortnight.

How we completed this review:

This was an unannounced visit and we thank the staff for their assistance and hospitality during the day.

We spoke with a number of patients and staff informally. Two of the detained patients agreed to meet with us in private during the course of our visit.

We toured the facilities available on the ward and saw a range of information provided to patients. This included notices and information leaflets providing a range of information for patients about the approaches to care on the unit, daily activities, advocacy, complaints and menus.

We reviewed the MHA records and care plans for five patients.

We observed patients and staff interactions and communication throughout the visit.

What people told us:

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

One patient said, “I’m alright today, mate.”

He told us that he was treated well and appeared to be very satisfied with the progress he was making. He told us that he had been in the psychiatric system for a long time, but thought he could be moving on.

Another patient we spoke with appeared to be discontented and talked to us about a range of issues which he felt needed addressing on the ward.

We spoke to the deputy charge nurse who explained that there was a recovery model approach to care. He told us, “we provide a very safe and secure environment for our patients.”

Staff worked with patients to develop their My Shared Pathway and care plans. Patients were given every encouragement to identify and state in their own words their issues and needs and how these should be addressed. To support this approach there were numerous information displays reinforcing the therapeutic approach to recovery, change and personal development.

A new observation policy had recently been introduced that focussed on ensuring meaningful engagement with patients at least every two hours and more frequently depending on the patients’ needs.

There were an extensive range of activities patients could participate in and facilities they could use. One of the patient’s we spoke with outlined to us his individual activity schedule which included woodwork, an art session, a session in the sports hall, attending the weekly community meeting and the smoking cessation programme.

The eight patients detained on the unit had been there for about two years. Although none had moved on to less secure care, we were given examples of how patients’ behaviour had changed positively over that two year period. Seclusion was rarely used.

Past actions identified:

At the last inspection completed on 18 December 2013, we identified concerns with:

- No visible assessments of capacity for patients in regard to treatment for

mental disorder whose treatment was authorised by a SOAD.

These concerns were fully addressed. We saw evidence of assessments of capacity to consent to treatment in the patient records we examined.

- That patients did not have a lockable area to store belongings in their bed area.

  These concerns had been partially addressed. We were advised that a lockable safe had been installed in one patient's bedroom on a trial basis. The intention was to put a safe in each bedroom in the near future.

- That it was unclear whether patients were being given copies of their section 17 leave forms.

  These concerns had been fully addressed. Every section 17 leave form we inspected had been signed by the patient. One patient we spoke with confirmed that he had been given a copy of his leave authorisation.

- Out of date T2 and T3 forms stored with the medication charts.

  These concerns had been fully addressed. There was a regular audit undertaken of medicine charts and certificates and out of date T2 and T3 forms were filed in the patient's records.

- That one patient had been administered medication over the prescribed limit in 24hours.

  This concern had been fully addressed at the time. The matter had been investigated and staff had undergone further training on prescribing limits.

Domain areas

Purpose, respect, participation and least restriction:

We were able to read the notes of the community meetings held on the ward on a weekly basis. The patients in the main appeared to have no significant recurring issues.

We were advised that patients were informed about their eligibility for an independent mental health advocate (IMHA) and an IMHA visits the unit once a week to speak to patients. We were shown advocacy information leaflets, which incorporated general information about eligibility for an IMHA, but not specific contact details. We also saw an advocacy poster. We did not see a poster that specifically advised patients about the IMHA service, which included contact details.

We saw information displayed about how to complain about the provider's services

and how to contact the patient advice and liaison service (PALS). We did not see complaints information displayed about how to complain to the service commissioner, Care Quality Commission (CQC) or Parliamentary and Health Ombudsman in accordance with guidance set out in the new Mental Health Act Code of Practice (CoP)

In the five records inspected, we saw that patients were regularly given an explanation of their rights and this was recorded and dated. We were concerned that there was a standardised care plan stating that rights will be explained on a weekly/fortnightly basis when we were advised that this was done on a monthly basis, which corroborated with the records.

We reviewed the patient files and were satisfied that staff were fully involving patients in the planning of their care. There were daily entries in the records for each patient. These noted the patient's daily activities and behaviour, mental state and any additional comments relevant to the patient's care and treatment.

We saw evidence in the patient files of comprehensive, individualised care plans, which related to the patients mental and physical health, risk management, activities and legal status.

We observed that patient and staff communications and interactions were calm, good humoured and supportive.

Admission to the ward:

We were able to inspect the MHA documentation for five patients. Four patients were detained under section 3 of the MHA and one was detained under section 37.

All the patients appeared to be lawfully detained.

Tribunals and hearings:

This domain area was not reviewed on this visit.

Leave of absence:

The section 17 leave forms we inspected appeared to adhere to guidance set out in the CoP. The leave authorisation was signed by the patient and a copy given to them. One patient we spoke with told us he had been given a copy of his leave authorisation.

We noted that patients were risk assessed prior to taking leave and a record of the outcome of the leave was recorded.

Transfers:
All the patients, whose records we inspected, had been transferred to the unit from other hospitals or areas. All the transfer documents were fully completed.
Control and security:
The unit was locked at the time of our visit. We were able to inspect the seclusion room and this appeared to comply with guidance set out in the MHA CoP.
Consent to treatment:
We saw that a patient's capacity to consent to treatment was assessed and a form had been devised to record the assessment. In the case of patients' assessed as lacking capacity to consent to treatment, we could find no best interests assessment setting out their treatment arrangements. We were advised that the MDT discusses the actions to take in the patient's best interests, but this did not appear to include consultation with carers or people nominated by the patient.
General healthcare:
We were advised that patients' physical health care needs were managed by two general practitioners, who visit the unit on a Monday and Thursday. It appeared that patients were having a physical health check annually.
Other areas:
There were no other issues to report on.

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 Purpose, Respect, Participation, Least Restriction	**MHA section:** 130A **CoP Ref:** Chapter 6

We found:

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

Your action statement should address:

How the trust will ensure that eligible patients are informed of their rights to an IMHA and have access to contact information which enables them to contact the IMHA directly if they wish in accordance with 6.15 CoP which states:

> 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 that help. This must include giving the relevant information both orally and in writing.

Domain 2 Purpose, Respect, Participation, Least Restriction	**CoP Ref:** Chapter 4

We found:

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

Your action statement should address:

How the trust will ensure that in accordance with 4.63 of the CoP:

> Information about how to make a complaint to the service commissioner, the CQC or Parliamentary and Health Ombudsmen should also be readily available. This should be displayed on all mental health wards. Complaining to the commissioner may be the right option if the individual is not comfortable complaining directly to the service provider or, if the complaint is under the Act, directly to the CQC. Information should include specific information about the right of detained patients to complain to the CQC (contact details below), and the local support available if they wish to raise a concern or complaint. This should be available in alternative formats, e.g. easy read or Braille. The information should be explained to all patients, including those who lack capacity to make decisions about complaints, have problems communicating (e.g. they do not read or write), or whose first language is not English.

Domain 2 Consent to treatment	**MHA section:** 58 **CoP Ref:** Chapter 13

We found:

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

Your action statement should address:

How the trust will ensure that clinicians act in accordance with 13.25 of the CoP which states:

> Care planning, including planning for discharge, must adhere to the steps for determining what is in the person's best interests set out in section 4 of the MCA. This ensures participation by the person and consideration of their wishes, feelings, beliefs and values and consultation with specified others (eg carers, attorneys and people nominated by the person) about the person's best interests.

Domain 2 Purpose, Respect, Participation, Least Restriction	**MHA section:** 132 **CoP Ref:** Chapter 34

We found:

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

Your action statement should address:

How the trust will ensure that care plans are updated and written in a way that indicates the intervention being undertaken.

During our visit, no patients raised specific issues regarding their care, treatment and human rights.

Information for the reader

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

Contact details for the Care Quality Commission

Website: www.cqc.org.uk

Telephone: 03000 616161

Email: enquiries@cqc.org.uk

Postal address: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA