Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Miranda House
Ward(s) visited:	PICU
Ward types(s):	Psychiatric Intensive Care Unit (PICU)
Type of visit:	Unannounced
Visit date:	6 March 2017
Visit reference:	37405
Date of issue:	16 March 2017
Date Provider Action Statement to be returned to CQC:	5 April 2017

What is a Mental Health Act monitoring visit?

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

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

This report sets out the findings from a visit to monitor the use of the Mental Health Act at the location named above. It is not a public report, but you may use it as the basis for an action statement, to set out how you will make any improvements needed to ensure compliance with the Act and its Code of Practice. You should involve patients as appropriate in developing and monitoring the actions that you will take and, in particular, you should inform patients of what you are doing to address any findings that we have raised in light of their experience of being detained.

This report – and how you act on any identified areas for improvement – will feed directly into our public reporting on the use of the Act and to our monitoring of your compliance with the Health and Social Care Act 2008. However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.

Our monitoring framework

We looked at the following parts of our monitoring framework for the MHA

Domain 1 Assessment and application for detention		Domain 2 Detention in hospital		Domain 3 Supervised community treatment and discharge from detention	
☐	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:

The Psychiatric Intensive Care Unit (PICU) at Miranda House in Hull is a 14 bedded mixed gender ward. There are 10 male beds and four female beds.

On the day of our visit there were 14 patients allocated to the ward. All patients were detained under the Mental Health Act 1983 (MHA). Two patients were placed on the ward from out of area.

The ward had a range of different activity areas which included an activity kitchen on the floor upstairs which patients could access with staff supervision. There was a large activities room on the ward and a separate gym with a variety of exercise machines.

There were separate male and female areas on the wards. Within the gender-specific areas were separate male and female lounges and dining rooms. There were 11 en suite bedrooms and three bedrooms which had a sink. Bathrooms and toilets were available in the gender specific areas. The ward had a large courtyard area which patients had supervised access to. There were also secure gardens attached to the gender-specific areas of the ward which patients could use to access fresh air and to smoke.

The ward manager told us that baseline staffing for the ward was five staff on a day shift to include two qualified nurses and four staff on a night shift to include two qualified nurses. The unit manager told us that staffing was increased at times to reflect clinical need on the ward. On the day of our visit there was increased staffing due to a patient being nursed in seclusion. Staff on duty included two qualified nurses and four healthcare assistants. The ward manager was not included in the numbers. The ward manager told us there were currently three qualified nurse vacancies being recruited to and the ward used agency staff and bank staff to support with staffing when needed.

Patients had access to a full time occupational therapist Monday to Friday. We found there was a vacancy for a full time activities coordinator. A psychologist visited the ward to meet with patients on a one to one basis and to provide peer supervision for staff.

The consultant psychiatrist was the responsible clinician (RC) for all of the patients on the ward. The ward manager told us the RC was full time and based on the ward. There was a speciality doctor for the ward.

How we completed this review:

This was a routine unannounced visit to the ward by a Mental Health Act Reviewer. On arrival at the ward we met with the ward manager. We had a tour of the unit.

We met with five patients in private and one patient with a staff member present.

Patient engagement forms were provided and none were returned completed.

We reviewed two sets of patients' records and viewed some seclusion records for episodes of seclusion which had taken place in 2017. We met with staff informally and interviewed the ward manager.

We provided verbal feedback to a staff nurse at the end of our visit.

What people told us:

Five patients spoke positively about staff on the ward "staff are generally good, most in it for the right reason", "staff are good, they keep us safe", "some staff are nice", "staff are alright", "we have agency staff a lot, different faces and don't understand us" and "the regular staff are sound".

We asked patients about care plans and were told "they write them and you sign them, there's no involvement", "I see care plans, I read and sign them" and "it's rare we get one to ones with staff - might get five minutes. I don't know if I have a named nurse".

Patients spoke about activities, "there's not a lot to do here except TV and pool", "if there's enough staff on then activities happen. We had an activities worker but she retired at Christmas" and "there's not much happening in the day".

Patients told us they were able to access fresh air when they wanted in the garden area.

Several patients raised concern about the previous weekend and explained that no section 17 leave took place due to an admission and low staffing levels. Patients told us leave normally does take place when planned. We observed staff supporting patients on leave on the day of our visit which was the first day following the weekend patients raised concern about.

We spoke with staff informally throughout the day. Staff told us they enjoyed working on the ward but explained it could be difficult at times due to the high level of clinical activity on the ward and staffing challenges.

Past actions identified:

The previous MHA monitoring visit was on 10 August 2015. The following issues was identified:

- The patients' files showed that patients were given information regarding their rights on arrival at the PICU but did not provide evidence that this had been repeated. The monthly audits and weekly checking proposed in the trusts previous action statement to address this issue did not appear to have been carried out.

  This issue remained and will be discussed later in this report and a further action point raised.

- Assessment of capacity to consent to treatment were not being completed for the majority of patients in accordance with the Code of Practice guidance.

  This issue remained and will be discussed later in this report and a further action point raised.

- No evidence that patients were being given information about the treatment being prescribed to them, where practicable.

  Patients did not highlight this as an area of concern on the day of the visit.

- One patient detained under section 3 did not appear to have had a nearest relative within the meaning of the Act.

  This was not an issue in the records reviewed.

- Patients' discharges from PICU were being delayed because beds were not available for them in less restrictive environments.

  The trust had taken action on this and this had been partially resolved. This has been detailed further in the report.

- Staff were not aware of a trust policy on the possession and use of mobile phones and mobile devices.

  We found staff were aware of the trust policy. However we have raised a further action point in regards to the blanket restriction in place for mobile phone usage for patients on the PICU ward.

- The staff we spoke with were unable to tell us whether the trust had any policies which guided the use of the restrictive interventions in regard to the low stimulus room.

  Staff we spoke to were clear regarding the use of the low stimulus room. We

were told that it was not a designated seclusion room and that patients could access this room when they wanted to. Staff told us if a patient was to be locked in the room it would be treated as seclusion and the trust seclusion policy followed. They explained this would be the case if any patient was locked in any room on the ward. The unit manager told us no patients have been locked in the low stimulus room since our last visit in August 2015. This issue appeared to have been resolved.

Domain areas

Protecting patients' rights and autonomy:

The ward was locked and entry was via an 'airlock' in the main reception area.

There was information on display about the independent mental health advocacy (IMHA) service available for patients. Staff told us patients were able to contact the IMHA service in private or ask staff to refer them. The unit manager told us that patients were referred to an IMHA at their request or by staff. Staff confirmed with the mental health legislation department that patients lacking capacity to instruct an IMHA were not automatically referred for IMHA in line with the Code of Practice (2015). Patients spoke positively about the IMHA service. There were no concerns raised about access to IMHA. Both staff and patients told us there was timely access to the IMHA service.

We saw information on display about how to complain and how to contact the Care Quality Commission (CQC).

We found lounges to be open for patients to access. The secure courtyard attached to the male part of the ward was left open for male patients to freely access and smoke when they wished. Staff told us the female secure courtyard was locked on the day of our visit and was opened at female patients' request. Staff told us this was due to risk issues from a female patient.

There were several blanket restrictions in place on the ward. All patients were not allowed access to their own mobile phones on the ward. We found patients were only allowed access to their mobile phones if they had unescorted leave from the ward. We found no patients had keys to their bedrooms. All patients received a pat down search on return from unescorted leave. We found none of these blanket restrictions were individually risk assessed or the impact of the blanket restrictions considered for the patients.

The ward manager told us that there was a monthly restrictive interventions group held by the trust and that the focus was to reduce restrictive practices on the wards.

We found patients had no lockable storage in their bedrooms for their personal possessions.

We found no patients had personal access to the internet on the ward. The ward manager told us that there was a computer in the activities room which had had access to the internet but that this was no longer available.

The ward manager told us that community meetings were to take place weekly on the ward for patients to attend. The staff member that had led on these meetings had left. Since December 2016, no community meetings had been recorded as having taken place. The last community meeting minutes seen were dated 28 December 2016.

We found on the two records reviewed that there were some concerns regarding section 132 rights. On one patients record we found their rights had not been repeated since 29 January 2017 when it was documented that they did not understand their rights. For another patient we found there was a delay in the reading of their rights on admission. The patient was admitted to the ward on 9 December 2016 and no record of section 132 rights been read until 18 December 2016.

The provider action statement received from the trust following our last visit stated that there would be a monthly audit of section 132 rights by band six staff. We did not see evidence of this taking place on the day of the visit.

Assessment, transport and admission to hospital:

We found all detention documents were available for scrutiny for the two records reviewed. We found there was a checklist in place completed by the mental health legislation department to scrutinise section paperwork.

The ward manager told us admissions were usually from acute wards and other hospitals. Staff told us admissions to the ward had come from low secure and community settings. Staff raised some concerns about the appropriateness of some admissions to the ward, and whether they met the criteria of requiring a PICU. The ward manager told us that the PICU has recently undergone an external two month review of the service and that they were awaiting the outcome of this.

Additional considerations for specific patients:

This area was not reviewed on the day of the visit.

Care, support and treatment in hospital:

Patients usually remained registered with their local general practitioner (GP). There were records in the files we reviewed that patients were having identified physical health needs met through attendance at relevant hospital appointments and referred to specialists where required. Staff told us that on admission patients had a physical health check.

There appeared to be daily activities available to patients. On the day of our visit the occupational therapist told us there had been an open activities session held on the ward for all patients to attend 1.30pm to 4pm. Some patients raised activities as a concern. We found the activities board on display was not up to date. We found that the occupational therapist was new to post and was running activities where possible but also completing individual occupational therapy assessments.

There was a baking group and breakfast group held during the week in the occupational therapy kitchen off the ward. The occupational therapist told us that they felt supported by the nursing team who offered additional activities on the ward.

Staff told us they felt once the activities coordinator post had been recruited that this would help in the delivery of ward activities. The ward manager told us this post would be over seven days to cover weekends.

We found patients' care plans were an area of issue. We found on the two records reviewed that patients had a care plan in place but they did not record the patient's views. The care plans were not signed by the patient and there was no record of whether the patient was offered a copy, as this section was left blank. We found there was no area to include the patient's carer and or family's views on the care plan.

We were unable to find record of a discharge care plan on the records reviewed. Some patients who spoke to us about their care plans told us the care plans were written and then they sign them and that they did not feel involved in this process.

We found that patients had a clinical review on a Monday and were told this was usually with a nurse and the RC which the patient could attend. There was a multi-disciplinary meeting on a Friday which we found patients were not invited to attend.

On our previous Mental Health Act monitoring visit we found there were issues on the assessment of capacity to consent to treatment not being completed for the majority of patients in accordance with the Code of Practice guidance. On the two records we reviewed, we found one patient had an assessment of capacity to consent to treatment completed. The other patient who was being treated under a T3 certificate, we found no record of a discussion about capacity to treatment. We also were unable to find record of the second opinion appointed doctor (SOAD) decision being communicated to the patient.

On our last visit in August 2015 we found that patients' discharges from PICU were being delayed because beds were not available for them in less restrictive environments. On this visit, we found the trust had taken action on this and a bed manager was now in post. However, we noted there were some patients admitted to the ward for lengthy periods, in receipt of unescorted leave and could be viewed as not in the most least restrictive environment. Staff told us that patient's discharges were delayed at times due to bed availability.

We viewed three seclusion records for episodes of seclusion that had taken place in 2017. We found five such episodes had taken place since January 2017 to 6 March 2017. The last seclusion was still underway on the day of the visit. We therefore did not view the seclusion room. We found the main issue on the three seclusion records reviewed was late nursing reviews where nursing reviews had happened but that they had not taken place within two hours in line with the Code of Practice (2015).

Leaving hospital:

In the two records reviewed, the patients did not have section 17 leave in place so we reviewed two others patients who had section 17 leave in place.

We found that leave was authorised through a standardised system, authorised on the basis of risk assessment and appropriately recorded. Section 17 leave included specific conditions where required and patients received copies of their leave.

We were not able to see record of whether patients carers or relevant others had received a copy of the leave and there was no space on the form for staff to indicate this.

Professional responsibilities:

There was evidence of tribunals and hospital manager's hearings taking place.

The trust had a checklist to support that the correct receipt of detention documentation was followed and this was then scrutinised by the MHA legislation department.

The ward manager told us that learning from incidents was shared and used to improve practice. The charge nurses attend a regular meeting and the expectation was that they then cascade this information to staff on the ward. The trust sent out 'blue light' information to staff by email if there were any significant events or learning. The ward manager told us information was shared through individual supervision and daily staff handover meetings.

Other areas:

Staff told us there was no physical health policy in the trust. We were told there was one in place but that this was removed and staff was not clear on the current arrangements.

We found the gardens had large amounts of cigarette ends on the floor particularly in the female garden. There were cigarette bins provided. One patient raised this as an issue and told us they felt the area should be swept regularly.

We were aware on the day of our visit a 17 year old patient had been admitted to the ward over the weekend. The patient was transferred to a specialist CAMHS ward out of area on the day of our visit. Staff told us that senior management were aware and had informed the relevant organisations.

We were told it was not within the trust policy to admit patients under 18 years old to this ward. This particular 17 year old patient had been admitted several times to the ward. Patients raised concern about this as to the impact on them due to staffing pressures as the patient was on 2-1 observations and their section 17 leave not taking place over the weekend period. The RC told us the patient was high risk to others and as a result was admitted in the interim until a specialist bed could be found out of area.

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 6
We found:	
The unit manager told us that patients were referred to an IMHA at their request or by staff. Staff confirmed with the mental health legislation department that patients lacking capacity to instruct an IMHA were not automatically referred for IMHA in line with the Code of Practice (2015).	
Your action statement should address:	
How you will demonstrate adherence with paragraph 6.16 of the Code of Practice (2015) paragraph, "If a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly."	

Domain 2 **Protecting patients' rights and autonomy**	**MHA section:** 132 **CoP Ref:** Chapter 4
We found:	
We found on the two records reviewed that there were some concerns regarding section 132 rights. On one patients record we found their rights had not been repeated since 29 January 2017 when it was documented that they did not understand their rights. For another patient we found there was a delay in the reading of their rights on admission. The patient was admitted to the ward on 9 December 2016 and no record of section 132 rights been read until 18 December 2016. The provider action statement received from the trust following our last visit stated that there would be a monthly audit of section 132 rights by band six staff. We did not see evidence of this taking place on the day of the visit.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraph: "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)."

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

We found:

There were several blanket restrictions in place on the ward. All patients were not allowed access to their own mobile phones on the ward. We found patients were only allowed access to their mobile phones if they had unescorted leave from the ward. We found no patients had keys to their bedrooms. All patients received a pat down search on return from unescorted leave. We found none of these blanket restrictions were individually risk assessed or the impact of the blanket restrictions considered for the patients.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraphs:

"1.6 Restrictions that apply to all patients in a particular setting (blanket and global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.

"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.

"8.7 Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred

activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights."

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

We found:

We found patients had no lockable storage in their bedrooms for their personal possessions.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"8.24 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, e.g. 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 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 8

We found:

We found no patients had personal access to the internet on the ward. The ward manager told us that there was a computer in the activities room which had, had access to the internet but that this was no longer available.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"8.21 Managers should develop policies on access by patients to e-mail and internet facilities by means of the hospitals IT infrastructure. This guidance should cover the availability of such facilities and rules prohibiting access

to illegal or what would otherwise be considered inappropriate material, e.g. pornography, gambling or websites promoting violence, abuse or hate. Additionally, the guidance should cover the appropriate use of social media such as Skype. A blanket restriction on access to the internet could breach article 8 if it cannot be justified as necessary and proportionate. For further details about not applying blanket restrictions see paragraphs 8.5 – 8.9."

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

We found:

The ward manager told us that community meetings were to take place weekly on the ward for patients to attend. The staff member that had led on these meetings had left. Since December 2016, no community meetings had been recorded as having taken place. The last community meeting minutes seen were dated 28 December 2016.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"1.10 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them."

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

We found:

Patients appeared to have some activities available daily. On the day of our visit the occupational therapist told us there had been an open activities session held on the ward for all patients to attend 1.30pm to 4pm. Some patients did raise activities as a concern. We found the activities board on display was not up to date. We found that the occupational therapist was new to post and was running activities where possible but also completing individual occupational therapy assessments.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015)

paragraphs:

"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. Care plans for detained patients should focus on maximising recovery and ending detention as soon as possible. Commissioners, providers and professionals should consider the broad range of interventions and services needed to promote recovery not only in hospital but after a patient leaves hospital, including maintaining relationships, housing, opportunities for meaningful daytime activity and employment opportunities."

Domain 2 **Care, support and treatment in hospital**	**CoP Ref: Chapter 1 , 24 and 34**

We found:

We found patients care plans were an area of issue. We found on the two records reviewed that patients had a care plan in place but they did not record the patient's views. The care plans were not signed by the patient and there was no record the patient was offered as this section was left blank. We found there was no area to include the patient's carer and or family's views on the care plan. We were unable to find record of a discharge care plan on the records reviewed. Some patients who spoke to us about their care plans told us the care plans were written and then they sign them and that they did not feel involved in this process.

We found that patients had a clinical review on a Monday and were told this was usually with a nurse and the RC which the patient could attend. There was a multi-disciplinary meeting on a Friday which we found patients were not invited to attend.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) 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 **Care, support and treatment in hospital**	**CoP Ref: Chapter 1**

We found:

On our last visit in August 2015 we found that patients' discharges from PICU were being delayed because beds were not available for them in less restrictive environments. On this visit we found the trust had taken action on this and a bed manager was now in post. However, we noted there were some patients admitted to the ward for lengthy periods, in receipt of unescorted leave and could be viewed as not in the most least restrictive environment. Staff told us that patient's discharges were delayed at times due to bed availability.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraphs:

"1.4 If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (eg their home or close to a family member or carer). In cases there the patient lacks capacity to make a decision about the location they would like to be close to, a best interest's decision on the location should be taken. This will promote recovery and enable the patient to maintain contact with family, friends, and their community.

"1.5 Any restrictions should be 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."

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

We found:

On our previous Mental Health Act monitoring visit we found there were issues on the assessment of capacity to consent to treatment not being completed for the majority of patients in accordance with the Code of Practice guidance. On the two records we reviewed we found one patient had an assessment of capacity to consent to treatment completed. The other patient who was being treated under a T3 certificate we found no record of a discussion about capacity to treatment. We also were unable to find record of the second opinion appointed doctor (SOAD) decision being communicated to the patient.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph:

"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.

"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."

Domain 2 Care, support and treatment in hospital	CoP Ref: Chapter 26

We found:

We viewed three seclusion records for seclusions that had taken place in 2017. We found five seclusions had taken place since January 2017 to 6 March 2017. The last seclusion was still underway on the day of the visit. We therefore did not view the seclusion room. We found the main issue on the three seclusion records reviewed was late nursing reviews where nursing reviews had happened but that they had not taken place within two hours in line with the Code of Practice (2015).

Your action statement should address:
How you will demonstrate adherence with the following Code of Practice (2015) paragraphs: "26.134 Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude."

Domain 2 **Leaving Hospital**	**MHA section: 17** **CoP Ref: Chapter 27**
We found:	
We were not able to see record of whether patients carers or relevant others had received a copy of the leave and there was no space on the form for staff to indicate this.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraphs: "27.22 Hospital managers should establish a standardised system by which responsible clinicians can record the leave they authorise and specify the conditions attached to it. Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know. A copy should also be kept in the patients notes. In case they fail to return from leave, an up to date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patients consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA))."	

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:	
Would like to see a chiropodist and dentist. Please meet with the patient to discuss this and update us of the outcome.	

Patient reference	F
Issue:	
Would like to know what section 17 leave they have in place and would like to know about when they will be ‘stepped down’ from the unit. Please meet with the patient to discuss and update us of the outcome.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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