Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated Individual:	Jules Williams
Region:	North
Location name:	Hawthorne Court
Location address:	St Mary's Lane, Beverley, Humberside. HU17 7AS
Ward(s) visited:	Hawthorne Court
Ward type(s):	Rehabilitation
Type of visit:	Unannounced
Visit date:	8 May 2015
Visit reference:	34140
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Date Provider Action Statement to be returned to CQC:	10 June 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Hawthorne Court is a ward for the rehabilitation of males and females with mental health problems, who are in the recovery phase of the illness. It is a locked rehabilitation ward, paired with St Andrews ward in Hull, 14 miles away. St Andrews is for patients who are further along the recovery pathway. Both wards were supervised by the same responsible clinician (RC).

Hawthorne Court has 22 beds, but only 18 of these were currently commissioned. There were 19 patients on the ward when we visited, 10 males and nine females. The nineteenth patient had been admitted into the separate rehabilitation flat directly from a mental health assessment, because there were no beds available on the admission wards. Seventeen of the patients were detained under the Mental Health Act 1983 (MHA).

The ward was staffed with two registered nurses and three nursing assistants during the day and one registered nurse and two nursing assistants at night. The two rehabilitation wards had two occupational therapists (OT's) and two OT assistants, a psychologist and a psychology assistant. Medical cover to both wards was provided by a consultant psychiatrist for four days per week and a junior doctor.

The ward is situated on two levels, with 10 male bedrooms and nine female bedrooms upstairs and two male and one female bedroom downstairs. We were told that the ground floor bedrooms were used for patients who had mobility problems. There was a flat on the first floor that was used to assess patients' independent living skills. The bedrooms were well appointed with en suite wet rooms. There were also gender specific bathrooms and toilets available. There was a good range of communal areas, including female specific areas. There were gender specific laundries which staff told us that they supported patients to use to develop their independence. There was a rehabilitation kitchen that was locked, but which staff would support patients to use when they asked. There was a large craft room which showed signs of regular use and a well-equipped games room.

How we completed this review:

We made an unannounced visit to the ward. We spoke with the nurse in charge, the RC and two other staff. We spoke in private with three patients and reviewed the notes of four patients. We toured the ward and fed back to the nurse in charge at the end of the visit.

What people told us:

Patients told us that they were generally happy with the ward. We were told that "The way that the staff treat you is marvellous", "I've found it quite OK here. I have no complaints whatsoever", "the food is quite good but sometimes it's a bit cold" and "every meal is excellent."

We were told that some patients did not think that they saw the RC often enough and that they did not always feel involved in their care planning. They also said that at times the level of staffing did not allow for leave or activities to take place.

Staff confirmed that the staffing levels affected the availability of patient activities. They also said that it was a good ward to work on, with time to spend one-to-one time with the patients. Staff were able to show that they understood the care process and the safeguarding process.

Past actions identified:

On our last visit to the ward on 21 August 2012 we found that patients were not always involved in their care planning. We found this to still be the case.

We found that one patient wanted more one-to-one time with their key worker. Whilst this was not found to be the case on this visit patients told us that they wanted to see the RC more often.

Other actions related to specific patients and were not relevant to this visit.

Domain areas

Purpose, respect, participation and least restriction:

The ward was able to achieve a suitable balance between safety, security and gender balance with minimal blanket restrictions on patients. There was a range of relevant information and leisure activities on the ward, together with an activity timetable. Staff told us that the activity timetable was not rigid and patients told us that there was not always anything to do.

We saw that the diverse needs of the patients were considered and we saw the faith room being used whilst we were there.

Staff told us that they had time to spend one-to-one time with patients every day, but some staff and some patients told us that they wanted to see the RC more often. There was not always evidence of patient involvement in the written care plans. Staff told us that they had been using the Recovery Star as a care planning and outcome tool. Although they currently recorded short term goals following the assessment, these were not detailed. The detailed care plans were in a more traditional format, which did not always show the level of patient involvement in the planning. We were told that the ward was moving to the long-term care plans from the Recovery Star, but expressed concerns about the level of detail that this would allow.

We were told by staff and patients that patients were not allowed to attend their own recovery meetings. The RC said that they made a point of speaking to each patient following their meeting.

All of the care plans that we saw were updated regularly.

Admission to the ward:

We reviewed the admission documents for four patients and found them all to be in order. We saw evidence of a system of scrutiny and each assessment that required one, had a report from an approved mental health professional (AMHP). Renewals were carried out appropriately.

We saw evidence that patients were informed of their rights under the Act and their right to an independent mental health advocate (IMHA) and legal advice. Qualifying patients were not routinely referred to an IMHA, although we were told that the trust had made a decision on the day of the visit that this would become the practice.

Tribunals and hearings:

We did not review this domain on this visit.

Leave of absence:

There was a system of authorising section 17 leave. We saw a blanket authorisation in some patients' notes for emergency medical treatment. This authorisation was different to the standard authorisations and did not have space to identify any restrictions or escort requirements. For one patient, this was signed by the patient's previous RC.

One patient was subject to restrictions under section 41 of the Act. The Ministry of Justice had authorised "escorted leave" for this patient. The section 17 leave authorisation indicated that this escort could be undertaken by staff or the patient's relatives.

Patients told us that they were offered copies of their leave forms.

Transfers:

We did not review this domain on this visit.

Control and security:
The ward did not have access to seclusion facilities. We were told that the two quiet rooms were used to de-escalate patients, but that this was not required often. If patients presentation deteriorated and they became very challenging we were told that arrangements would be made to transfer the patient to a more suitable ward. We were told that this had happened with a patient the previous week. We saw that there were complete records of observations, which related to patients care plans. Security on the ward was appropriate to its function, with high risk materials being restricted. The ward had a level of anti-ligature that reflected the risk of the patients.
Consent to treatment:
We found inconsistent recording of assessment of capacity to consent to treatment. We saw good practice in an assessment for capacity to consent to treatment attached to a T2 certificate. We were told that assessments were undertaken on renewal of T2 certificates and recorded in the daily notes. Staff were unable to find these for us. We saw one assessment of capacity and best interest that related to the patient's capacity to understand their detention, but not to consent to treatment. We saw that T2 and T3 certificates were with the medication cards when they were required. We found one patient who had been assessed by a second opinion appointed doctor (SOAD) and had treatment authorised by a T3 certificate. There was a subsequent T2 certificate authorising an additional medication.
General healthcare:
Patients were either registered with their own GP or with a local GP who visited the ward regularly and saw all of the patients who needed GP services.

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	**CoP Ref:** Chapter 1

We found:

That patients did not always feel involved in their care planning. The care plans did not always reflect patients' involvement.

Care plans drawn from the Recovery Star documentation were not detailed about the care required. Some staff expressed concern about the fitness of the long-term care plan element of the Recovery Star when this was implemented.

Patients were not allowed to attend their own recovery meetings.

Your action statement should address:

How you will ensure that patients are fully involved in all aspects of planning their care, in line with the requirements of the Code of Practice.

How you will be able to demonstrate that the proposed changes to the care plan model that is used will meet the needs of the patients, staff and be compliant with the requirements of the Code of Practice.

Paragraph 1.7 of the Code of Practice states:

> 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.

Paragraph 1.10 states:

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

We found:
Patients and staff reported that staffing levels were such that at times patient leave and activities were cancelled. Patients told us that they did not see their RC as often as they wanted.
Your action statement should address:
How you will demonstrate that the staffing level on the ward and the level of medical cover is appropriate to the needs of the patients. 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. 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 Leave of absence	**MHA section:** 17 **CoP Ref:** Chapter 27

We found:
That a leave authorisation proforma for granting leave for emergency treatment did not allow for the identification of leave and escort parameters. We found that one emergency leave proforma had been signed by a previous RC and not by the patient's current RC We found that the escort levels section of the leave authorisation had not been completed on any of the forms that we saw. We found that one restricted patient had been granted escorted leave by the Ministry of Justice. The section 17 authorisations signed by the RC identified that the patient could be escorted by either staff or relatives. Expired section 17 leave authorisations remained in the patients' notes and were not struck though or cancelled.
Your action statement should address:
How you will ensure that leave authorisation for emergency medical treatment clearly identifies any conditions which the RC considers to be in the interest of the patient or of the public. Paragraph 27.9 of the Code of Practice states: "Responsible clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people." How you will ensure that expired or rescinded leave forms are clearly marked or removed from the patients record and that current leave authorisations are signed by the RC, in compliance with section 17 of the MHA. Paragraph 27.8 of the Code of Practice states: Only the patient's responsible clinician can grant leave of absence to a patient detained under the Act. Responsible clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual responsible clinician (e.g. if they are on leave), permission can be granted only by the approved clinician who is for the time being acting as the patient's responsible clinician. Paragraphs 27.27 and 27.29 make the distinction between escorted leave and accompanied leave. How will you assure us that the arrangements for section 17 leave for the patient subject to restrictions under section 41 of the MHA are within the parameters established by the Ministry of Justice for this patient, identified as escorted leave in the authorising letter?

Domain 2 Consent to treatment	**MHA section:** 58 & 63 **CoP Ref:** Chapter 24

We found:
That there was inconsistent recording of the assessment of patients' capacity to consent to treatment.
Your action statement should address:
How you will ensure that the assessment of capacity to consent to treatment is recorded at first treatment for mental disorder and at the authorisation of subsequent T2 and T3 certificates. Paragraph 24.32 of the Code of Practice states: "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." and "all assessments of an individual's capacity should be fully recorded in the patient's notes."

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
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