Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Willerby Hill
Ward(s) visited:	Ullswater, The Humber Centre
Ward types(s):	Secure ward - Medium
Type of visit:	Unannounced
Visit date:	10 July 2017
Visit reference:	37831
Date of issue:	19 July 2017
Date Provider Action Statement to be returned to CQC:	8 August 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Ullswater is a 12 bedded, medium secure unit for males with a learning disability based within the Humber Centre.

On the day of our visit there were six patients allocated to the ward, all were detained under the Mental Health Act 1983 (MHA).

The acting ward manager told us that baseline staffing levels for the ward was five staff to include two qualified nurses and three healthcare assistants. On a night shift the baseline staffing was one qualified nurse and three healthcare assistants. On the day of our visit the ward was running below the baseline staffing levels. There was one qualified nurse on shift who was the acting ward manager and five healthcare assistants. There was one patient being nursed in seclusion and one patient on constant observations. On our last MHA monitoring visit running below the required staffing levels was highlighted.

All patients had a bedroom with an en suite attached.

There was one consultant psychiatrist for the ward who acted as responsible clinician (RC) for the patients. There was also input from occupational therapy (OT) and the psychology department.

How we completed this review:

This was a scheduled unannounced visit to the ward by a Mental Health Act Reviewer.

We met the acting ward manager on our arrival to the ward. We met with three patients in private and also met with the patient in seclusion where staff were present. Other patients declined to meet with us.

We interviewed the acting ward manager and received a tour of the ward. One patient allowed us to see their bedroom.

We reviewed three patients' records.

We gave verbal feedback to the acting ward manager, modern matron for Ullswater and Clinical Care Director for the care group at the end of our visit.

What people told us:

Patients spoke about staff and told us "some staff are alright, some staff have

attitudes" and "staff are too quiet they don't tend to do much".

Patients spoke about staffing shortages on the ward "needs to be more staffing levels, very short here", "they are regularly short staffed", "staffing needs improving here" and "not enough staff about".

We asked patients their thoughts on the food and were told "food can be ok, sometimes it's rushed, and half of it's bought in", "the food is on a three weekly menu and we get the same food all of the time".

From our observations and informal discussions with staff they also mentioned short staffing on the ward as an issue.

Past actions identified:

The previous MHA monitoring visit was on 28 August 2014. The following issues were identified:

- A patient whose treatment for mental disorder was authorised by a form T2 had been signed by a previous consultant.

This was not an issue on the patient's records we reviewed.

- Some patients did not have a visible assessment of their capacity in relation to treatment for mental disorder from the RC.

This issue was resolved on the patient's records we reviewed.

- A care plan which made reference to the use of mechanical restraint when a patient was recovering from an anaesthetic. We were told there was not a trust policy covering the use of mechanical restraint.

We did not find this to be an issue on the day of our visit.

- Care plans that had not been reviewed or evaluated.

This issue remained on the patient records we reviewed.

- The documented seclusion reviews were recorded in several different places within the patient record. During one period of seclusion several days of medical reviews could not be located.

At this visit we found that all seclusion reviews were entered onto one electronic recording system. At this visit seclusion medical reviews could not be located. This issue remained.

- The patients we spoke to told us that section 17 leave had been cancelled due to staffing issues on the ward. This was confirmed with staff we spoke

with.

This issue remained. Patients told us of leave being cancelled due to staffing shortages or postponed to another day.

Domain areas

Protecting patients' rights and autonomy:

In the three patient records that we reviewed, patients had been informed of their legal position and rights as required under the MHA section 132. However, we found that for two patients they had been informed of their rights under section 132 in June 2017 but both had not been informed of their rights since October 2016. There care plans stated to inform them of their rights under section 132 on a three monthly basis.

The acting ward manager told us there was a staff member identified as a carer lead on the ward. There was a monthly carer event held at the Humber Centre on a Saturday.

The acting ward manager told us that patients had a community meeting weekly and that this was recorded.

Staff told us that patients were not subject to personal or rooms searches unless there was an individual risk issue. We were told in these cases this would be individually care planned and discussed with members of the multi-disciplinary team (MDT).

Patients we met told us they were generally happy with their bedroom areas. We found patients had their own lockable storage in their rooms. Patients had their own keys to be able to access their own bedrooms when they wished. Staff told us that patients who did not have their own room key had a care plan in place around this.

There was a secure garden area available to patients on the ward. Patients were required to ask staff to access this area. We did not find the impact of this to be considered for each individual patient. The acting ward manager told us that there had recently been an agreement for this door to be unlocked for patients to access this area without the need to ask staff to unlock the door. The acting ward manager was in the process of updating relevant risk assessments and ensuring the garden was safe to allow this to happen.

Patients had access to a lounge area with a television and other activities available. There were hot and cold drinking facilities available for patients to be able to make their own drinks when they wished. Within the lounge area we saw information on display about the independent mental health advocacy (IMHA) service and the CQC. Other relevant information was also on display.

Staff and patients told us that there was an IMHA service available. Patients who lacked capacity to instruct an IMHA were automatically referred to the IMHA service. Staff told us that the IMHA service provided an open session on the ward every Wednesday. They attended multi-disciplinary team meetings at the patient's request. The visiting IMHA also visited the patients in seclusion at their request. Staff and patients told us there was timely access to the IMHA service and raised no

concerns.

Patients were unable to access their own mobile phone on the ward. The acting ward manager told us that the trust was looking at this issue. The trust were in the process of producing a policy to look at this on a service wide level.

The acting ward manager told us that patients were able to have access to the internet on the computer that was located on a corridor near the ward. We were told this was booked out daily for patient use. The ward had a computer for patients use but this was for patients to use the word processor and had no internet access.

Assessment, transport and admission to hospital:

We found detention documents were available for scrutiny. We found approved mental health professional (AMHP) reports present where this was required. Ministry of Justice paperwork was present where required. On the patient records we reviewed all detention documents appeared in order.

Patients were admitted to the hospital from a range of settings. The acting ward manager told us that usually admissions were for patients who required a step up in security from low secure settings or prison transfers.

Additional considerations for specific patients:

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

Care, support and treatment in hospital:

We found evidence of the RC making a record of patients' capacity to consent to treatment. In one patient's records we reviewed we were not able to find a record the patient had been informed of the second opinion appointed doctor (SOAD) visit outcome and recommendation. No reason was recorded for not doing this.

There was an OT lead for the ward that was supported by several activities coordinators. The acting ward manager told us there were activities available to patients over a seven day period and that OT staff covered weekends and worked later in the day. There was a weekly planner of activities. On the day of our visit we were told there was a walking group being held off the ward in the morning and we observed in the afternoon some patients baking cakes in the kitchen with staff. This was for the open day event due to be held at the Humber Centre the following day.

Some patients we met did tell us that the shortages of staff on the ward impacted on the level of activities available, one to ones with nursing staff and access to section 17 leave. One patient told us they felt there was enough activities and that they wanted to go to the café on the day of our visit but was unsure if this was possible due to staffing shortages. One patient told us that they were "bored" and told us "there's a lack of activities and I don't get to know what's on".

Staff told us that patients were registered with a general practitioner (GP). The GP visited the Health Hub which was located within the Humber Centre on a weekly basis. The acting ward manager told us that there were general nurses also available there to see patients. Staff were positive about the health hub service and how it met patient's physical healthcare needs.

The acting ward manager told us that patients would receive a physical health screen on admission and then annually. However, we were unable to find record of this in the patient's records we reviewed. Staff confirmed that they do routine physical health monitoring.

Staff told us that patients were seen within the multi-disciplinary team meeting every three to four weeks. It was difficult to see what was covered in some multi-disciplinary team meetings as the minutes were left blank in some areas so it was unclear if certain areas had been reviewed within the meeting.

We viewed the care plans in the three patient records we viewed. We found minimal patients and or carer involvement recorded within the care plans or care plan reviews. For some care plans we found they had not been reviewed for a significant period of time. This was an issue identified on our previous MHA monitoring visit. We found that care plans did not have evidence of discharge planning.

We found risk assessments were completed on the patient's records we reviewed and risk management care plans in place.

We reviewed the seclusion records for one episode of seclusion. We found a lack of medical reviews. For example on the day of our visit there were no medical reviews completed for the patient that was in seclusion. For other days we found only one medical review documented on the patients records. We found that several two hourly nursing reviews were late.

We were unable to fully review the seclusion rooms for the ward due to both being in use on the day of our visit. One seclusion room was in use by another patient from a different ward.

Leaving hospital:

In the three patient records we reviewed, two patients had section 17 leave in place. Staff told us that section 17 leave was risk assessed within the multi-disciplinary team meeting prior to approval by the RC. We found the minutes from multi-disciplinary team meetings were not always fully completed so it was unclear in some patient's records whether leave had been discussed and reviewed.

We found leave was appropriately recorded and documented specific conditions where required. We found leave authorisations indicated whether they had been shared with the patient or if the patient had refused a copy. We found some old section 17 leave authorisations on file which had not been cancelled or struck through; this could have caused staff confusion. We were also unclear from the section 17 authorisation forms we viewed whether relevant others i.e. family/care

coordinator (where applicable) had been offered a copy of the leave form.

The acting ward manager told us there had been one patient gone absent without leave (AWOL) from unescorted leave within the last six months. The patient was AWOL overnight from the ward. We were told CQC were notified and relevant others as per trust policy.

Staff told us that when patients were discharged this was usually to locked rehabilitation wards. However we were told there was the possibility for patients to be discharged into the community or low secure wards when required. On occasions patients had to be transferred from the ward to a high security hospital.

Professional responsibilities:

The acting ward manager told us that admissions to the ward were usually planned and followed assessments by members of the multi-disciplinary team.

Tribunals and hospital manager's hearings took place when required and we found these recorded in the patient's records we reviewed.

The acting ward manager told us that learning from incidents was shared on the ward and used to improve practice. They told us that the modern matron takes the lead on undertaking debriefs on the ward. The acting ward manager told us that they tried to do daily reflections on the ward with staff.

The acting ward manager told us that they felt staff were skilled in providing safe and therapeutic responses to patients who were unsettled or displayed disturbed behaviours. They explained that staff used the least restrictive option and de-escalation whilst ensuring the environment, patients and staff were kept safe.

Other areas:

On the day of our visit the ward was running below the baseline staffing levels running below the required staffing levels was also highlighted at our last MHA monitoring visit. This issue was raised in feedback and the inspector for the service was informed following our visit. We have not identified this as a separate issue as the inspector followed this up with the provider immediately following our visit.

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**	**MHA section:** 132 **CoP Ref:** Chapter 4

We found:

In the three patient records that we reviewed, patients had been informed of their legal position and rights as required under the MHA section 132. However, we found that for two patients they had been informed of their rights under section 132 in June 2017 but both had not been informed of their rights since October 2016. There care plans stated to inform them of their rights under section 132 on a three monthly basis.

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 8

We found:

There was a secure garden area available to patients on the ward. Patients were required to ask staff to access this area. We did not find the impact of this to be considered for each individual patient. The acting ward manager told us that there had recently been an agreement for this door to be unlocked for patients to access this area without the need to ask staff to unlock the door. The acting ward manager was in the process of updating relevant risk assessments and ensuring the garden was safe to allow this to happen.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 8.5:

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

and 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 patients human rights."

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

We found:

In one patient records we reviewed we were not able to find recorded the patient being informed of the second opinion appointed doctor (SOAD) visit outcome and recommendation.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 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 1 and 24

We found:

The acting ward manager told us that patients would receive a physical health screen on admission and then annually. However, we were unable to find record of this in the patient's records we reviewed.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 1.17:

> "Physical healthcare needs should be assessed and addressed including promotion of healthy living and steps taken to reduce any potential side effects associated with treatments."
>
> and 24.57
>
> "Commissioners and providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. The physical needs of patients should be assessed routinely alongside their psychological needs. Commissioners need to ensure that long term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral."

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

We found:

Staff told us that patients were seen within the multi-disciplinary team meeting every three to four weeks. It was difficult to see what was covered in some multi-disciplinary team meetings as the minutes were left blank in some areas so it was unclear if certain areas had been reviewed within the meeting.

We viewed the care plans in the three patient's records we viewed. We found minimal patient and or carer involvement recorded within the care plans or care plan reviews. For some care plans we found they had not been reviewed for a significant period of time. We found that care plans did not have evidence of discharge planning. This was an issue identified on our previous MHA monitoring visit.

Your action statement should address:

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

and 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."

and 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 26

We found:

We reviewed the seclusion records for one episode of seclusion. We found a lack of medical reviews. For example on the day of our visit there were no medical reviews completed for the patient that was in seclusion. For other days we found only one medical review documented on the patients records. We found that several two hourly nursing reviews were late.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 26.131:

"Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays. A provider's policy may allow different review arrangements to be applied when patients in seclusion are asleep."

and 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 found some old section 17 leave authorisations on file which had not been cancelled or struck through; this could have caused staff confusion. We were also unclear from the section 17 authorisation forms we viewed whether relevant others i.e. family/care coordinator (where applicable) had been offered a copy of the leave form.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 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	A
Issue:	
Patient A told us the ward has community meetings but explained that senior management staff (Above ward manager level) rarely attended and they would like them to be present more at these meetings. Patient A told us that he wanted to highlight his concerns about the ward having moved towards the least restrictive principle. He explained that he is concerned for staff who he perceived felt unable to use restraint on occasions where they once would have been able to previously. He explained that he feels some staff may be afraid to pull their alarms. He gave an example of a staff member in a kitchen where a patient was being threatening towards them on the outside and them feeling unable to pull their alarm. Patient A felt the ward was losing staff due to being more least restrictive and not being able to restrain patients when this was needed. Please meet with patient A and update us of the outcome.	

Patient reference	C
Issue:	
Patient C did not raise any individual issues. We asked staff to inform patient C of his section 132 rights and the MHA section he was detained under as he told us that he was not under a section of the MHA. Please meet with the patient to ensure they are aware of the MHA section they are detained under and their section 132 rights.	

Information for the reader

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