# Mental Health Act 1983 monitoring visit

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| **Provider:** | Humber NHS Foundation Trust |
| **Nominated individual:** | Hilary Gledhill |
| **Region:** | North |
| **Location name:** | Newbridges |
| **Ward(s) visited:** | Newbridges |
| **Ward types(s):** | Acute ward for adults of working age |
| **Type of visit:** | Unannounced |
| **Visit date:** | 30 May 2017 |
| **Visit reference:** | 37622 |
| **Date of issue:** | 12 June 2017 |
| **Date Provider Action Statement to be returned to CQC:** | 30 June 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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 | |
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| ☐ | 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:**

Newbridges is situated in East Hull and has 18 beds for the admission and treatment of men with mental health problems. Patients were transferred from other wards within the trust or were admitted directly onto the unit. On the day of the visit there were 20 patients allocated to the unit. Three were on leave. 17 beds were available as one bedroom was being refurbished. Thirteen patients were detained under the Mental Health Act (MHA).

We met with one of the two deputy ward managers, who assisted us during the course of our visit.

There was a TV lounge with an adjacent pool room, a clinic room, a quiet room, a dining room and a range of rooms off the ward for patient activities. Patients had their own ensuite bedrooms, which were on the first floor. There was also patient access to a garden and smoking area.

There were five qualified nursing staff and four support staff on duty at the time of our arrival. In addition, there was an occupational therapist (OT) and OT assistant; an activities co-ordinator; one consultant psychiatrist with junior medical support and a psychologist and psychology assistant.

**How we completed this review:**

This was an unannounced visit to Newbridges. We spoke with three patients in private and with two other patients informally.

Six patients completed patient engagement forms indicating their opinions of their care and treatment.

We were shown around the unit and observed the environment and patient interactions with staff. We reviewed two patients clinical records, care plans, assessments and mental health act documentation.

We spoke with both the deputy ward managers about our last visit as well as care and treatment approaches on the ward. We spoke with the responsible clinician and nursing staff.

**What people told us:**

We spoke with three patients in private.

One patient was full of praise for the staff and the way he had been treated. He

said, “The doctors and nurses are first class”. He also said, “the food is absolutely lovely”.

Another patient we spoke with was generally happy with his care and treatment. He mentioned that his section 17 leave had been postponed on a couple of occasions. He said he thought it was because there were not enough staff.

Another patient we spoke with said the staff were, “Absolutely brilliant” and that “Staff can’t do enough for you”.

Six patients completed patient engagements forms. In the main, these patients appeared very satisfied with the care and support they received from medical, nursing and therapy staff. Several patients wrote very positively about the staff commenting that they were ‘excellent’; ‘really good and helpful’ and ‘brilliant’. Three patients appeared to be uncertain about whether they had a care plan. The ward environment was also well regarded. The patients felt the food was very good.

We spoke with the deputy ward manager. We used the findings from the previous visit as a way of discussing a range of changes that had taken place since that visit.

The deputy ward manager told us that since the previous visit the unit had been recruiting new staff and the staffing establishment had been reviewed and increased.

The trust had implemented the use of an electronic patient information system on the unit. It was in its first week of operation. Consequently, the staff were still learning how to use the new system. The unit was also in the process of creating new patient files which incorporated the patient’s MHA documentation. Longer term it was expected that MHA documents would be uploaded onto the electronic patient information system.

All staff had received further training on the management of patients in seclusion following the previous visit.

The unit had an activities co-ordinator who arranged activities for patients in and out of the unit. A number of patients we subsequently spoke with were complimentary about the activity co-ordinators work and mentioned trips they had arranged for them.

**Past actions identified:**

The last mental health monitoring visit took place on 31 May 2016 and the following concerns were raised on that visit.

- Staff did give patients information about their rights as required by section 132 on admission, however we found little evidence that information was repeated as required by the Code of Practice. Although file audits were

undertaken on the unit, we did not find evidence of improvement in practice as a result.

These concerns appeared to have been fully addressed in the files we reviewed.

- The detention documents were missing on one patient's file, the unit could not access copies of these documents on the day of our visit and so could not verify the patient's detention. On another file we found the patient had been regarded as informal but the paperwork to verify this change was not present with the detention documents.

  These concerns had been fully addressed in the files we reviewed. However, it was difficult to find the requisite detention documents in amongst the other documents filed in the MHA section of the file. The ward staff also had difficulty finding the current detention documents and whether they were the current authority for detaining the patient.

- Patients told us there was insufficient staff to support them during their admission. They said they did not have one to one time with their key worker as a result. They told us they were not involved in care or discharge planning. They said escorted section 17 leave could not be facilitated often enough to promote recovery. They did not feel safe at times on the ward. There was little to do.

  These concerns had been partly addressed. Staffing levels appeared to have been increased. The patient's we spoke with had one-to-one time with their key workers. It did not appear that there was a coherent and concise approach to care or discharge planning, which we address in this report. One patient complained about section 17 leave being postponed. We were told by the deputy ward manager this was because staff were not available to escort him because very acutely ill patients were needing close observation at the time of his leave.

- No record on patients notes of responsible clinician's (RC) discussion with them about their medication to establish their capacity to consent to treatment under forms T2.

- These concerns had been fully addressed and we saw evidence that the RC was assessing capacity to consent to treatment. Concerns in the management of a patient in seclusion. Nursing staff had not reviewed the patient every two hours in line with the trust's seclusion policy and the Code of Practice. The patient had received rapid tranquillisation. Fluid input and output were not recorded rigorously, despite the patient's recent problems with fluid retention requiring hospital admission. One multi-disciplinary review consisted of the RC and a nurse. We did not establish whether telephone consultation took place with another professional if this was out of office hours.

This concern appeared to have been addressed in current practice. We reviewed the seclusion record for one recently secluded patient and procedure for seclusion and monitoring appeared to be in accordance with the Code of Practice guidance.

- We visited on 11 December 2014 prior to the unit's expansion to 18 beds. We found patients did not have keys to their rooms or a place to secure their belongings. We asked how the trust would enable patients to secure their belongings in a way that was compatible with the least restriction principle of the Code of Practice. On this visit we found this was still the case and raise it again below. We were concerned that this was a blanket restriction rather than one based on risk assessment for each patient.

  This concern was still present. In one room we observed a patient's loose change lying on the bedroom floor. It appeared that anyone could have gone into the bedroom and taken this money. We were told that some discussion had been had about a key card system of entry to bedrooms, but the deputy ward manager did not know what progress, if any, was being made on this proposal.

## Domain areas

**Protecting patients' rights and autonomy:**

The independent mental health advocate (IMHA) visited the ward twice a week and an information poster was displayed on a noticeboard.

Patients were able to use their mobile phones on the ward.

There appeared to be a blanket restriction on patients' access to the internet on the unit. Patients could only access the internet if they had internet access from their own mobile telephones or laptops.

We also note the blanket restriction that has been highlighted on previous visits that patients do not have keys to their bedrooms or any lockable storage available in their bedrooms.

We asked whether any progress had been made in regard to patients being able to lock their bedrooms. We were told that some discussion had taken place regarding a key card system. The ward manager had mainly been involved with those discussions and was on leave, very little information was available about this matter.

Smoking was allowed in the garden area. There were cigarette tabs around the smoking area floor, which looked dirty and unkempt. We were told that one of the patients had overturned a bin, but this did not fully explain why it was so dirty. We enquired whether this area was swept regularly, but it did not appear to be part of any cleaning schedule.

We could not find in the records we reviewed whether patients consent was sought to share information with carers. We were told that staff were developing an approach to carer involvement on the ward. There was a notice posted on the noticeboard about a carers meetings being held locally.

Staff were trying to set up a carers support group for carers to build on work that was happening in the trust to support carers.
The unit had given one member of staff the responsibility for ensuring that detained patients were regularly given an explanation of their rights under section 132 MHA.

In the two patient records we reviewed there was evidence of attempts being made to explain section 132 rights to patients. The five patients, who were detained and completed our patient engagement form indicated they were content with the rights information they received.

We observed patients being treated with respect and dignity by nursing staff. Patients' questions and concerns were listened to and addressed and the rapport between patients and staff appeared good humoured.

**Assessment, transport and admission to hospital:**

The deputy ward manager told us that staff had access to training about the Mental Capacity Act (MCA).

We saw evidence in patient files of assessments of capacity being undertaken for consent to treatment. It appeared the trust used several different documents for assessing capacity associated with the respective treatment process.

**Additional considerations for specific patients:**

We did not review this area.

**Care, support and treatment in hospital:**

We initially planned to review three patient records, but we found it difficult to navigate the paper files, which contained day to day progress notes, recovery star formulations and reviews, risk assessments, various other assessments, MHA documents and doctors notes. Consequently we reviewed two paper files.

The two patient records we reviewed had an assessment of capacity to consent to treatment on admission in place. We did not find that patients assessed as lacking capacity had care plans in place to support them with their needs where they lacked capacity to make decision about their care.

In one patient's file we noted that the patient was being treated urgently with Electro Convulsive Therapy (ECT) under section 62 MHA. The RC showed us the assessment for consent to ECT document filed with one patient's ECT notes. Processes were in place in regard to the application of the section 62. A second opinion appointed doctor (SOAD) had been to visit the patient and certify treatment under a T6 form for a patient who lacks capacity to consent to treatment.

We reviewed the seclusion record for one patient who had recently been in seclusion. The procedure for seclusion and the monitoring process appeared to have been undertaken in accordance with the Code of Practice guidance.

Risk assessments were completed routinely for patients admitted to the unit.

We were advised that staff used the recovery star system as the basis for planning and reviewing care. The recovery star records we reviewed identified a range of the patient's needs and these were reviewed regularly with the patient.

We could not find a concise care plan document which drew together the range of information in the patient's files and set out what the patient's issues were, what interventions were planned and who would take the professional lead initiating those interventions. Our findings were reflected by the patients we spoke with who did not

know whether they had a care plan. None of the patients we spoke with appeared to have been given a copy of their care plan. The care plans did not contain patients/carers views.

**Leaving hospital:**

In the two records we reviewed the patients had been granted leave of absence.

We noted when we reviewed the patient's record who had been prescribed ECT that section 17 leave of absence had not been granted for him to travel to the ECT unit. There was a signed leave of absence form in the file to grant leave for emergency treatment, but not treatment prescribed in the unit and administered elsewhere in the trust.

We noted in the other record we reviewed that a patient's parents had not been given a copy of the leave authorisation despite leave been granted for the patient to go to their parent's home.

**Professional responsibilities:**

We reviewed the MHA documentation of two patients detained under the MHA.

The patients appeared to be lawfully detained.

**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**<br>**Protecting patients' rights and autonomy** | **CoP Ref:** Chapters 1,8,26 |
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| **We found:** | |
| There were blanket restrictions in place in regard to internet access and patients' access to secure their belongings in a way that was compatible with the least restriction principle of the Code of Practice. The previous provider action statement stated that a review of current practice and estate limitations would be undertaken to address access and security of rooms based on individually assessed needs. We did not see evidence of this action being undertaken in accordance with Code of Practice guidance | |
| **Your action statement should address:** | |
| How the trust will act in accordance with paragraphs 1.6, 8.21, 8.24 and 26.18 of the MHA Code of Practice (CoP) which state:<br><br>1.6 'Restrictions that apply to all patients in a particular setting (global or blanket restrictions) should be avoided…'<br><br>8.21 Managers should develop policies on access by patients to e-mail and internet facilities by means of the hospital's 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, eg 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.<br><br>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 others, e.g. razors.'<br><br>26.18…'giving each patient a defined personal space and a safe place to keep their possessions.' | |

| **Domain 2**<br>**Protecting patients' rights and autonomy** | **MHA section:**<br>**CoP Ref:** Chapter 1 |
|---|---|
| **We found:** | |

Patients we spoke with did not know whether they had a care plan and none had been given a copy of their care plan. We could not find concise care plans in the patients' records. The care plans did not contain patients/carers views.

**Your action statement should address:**

How the trust will act in accordance with empowerment and involvement principle and in particular paragraphs 1.7 and 1.9 of the MHA CoP which state:

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.'

1.9 'The patient's choices and views should be fully recorded. Where a decision in the care plan is contrary to the wishes of the patient or others the reasons for this should be transparent, explained to them and fully documented.'

| **Domain 2**<br>**Leaving hospital** | **MHA section:** 17<br>**CoP Ref:** Chapter 27 |
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**We found:**

One patient being transported to another unit for ECT without leave of absence being granted for this purpose.

Another patient had been granted leave to their parents' home in accordance with section 17 MHA, but their parents had not been given a copy of the leave authorisation.

**Your action statement should address:**

How the trust will ensure that leave is granted in accordance with paragraphs 27.9 and 27.22 of the MHA CoP which states:

27.9 '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.'

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

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| is taken in accordance with the Mental Capacity Act (MCA)). |

During our visit no 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.

## Information for the reader

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