Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated Individual:	Jules Williams
Region:	North
Location name:	Millview
Location address:	Castle Hill Hospital, Castle Road, Cottingham, Humberside. HU16 5JQ
Ward(s) visited:	Millview Court
Ward type(s):	Acute admission
Type of visit:	Unannounced
Visit date:	20 October 2015
Visit reference:	35008
Date of issue:	29 October 2015
Date Provider Action Statement to be returned to CQC:	18 November 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Mill View Court is a mental health assessment and treatment facility with 10 beds for male and female patients. There were nine patients on the day of our visit. Five patients were detained. All bedrooms were en suite. Patients could lock their rooms from the inside.

Staff worked early, late and night shifts but were about to introduce a twilight shift from 1500 to 2300 to support the staff team at busy times. There were two registered nurses and two healthcare assistants on the early shift and five staff on the late shift in addition to the ward manager and the activities coordinator. A clinical psychologist and occupational therapist were also in attendance during part of our visit.

Patients had access to an open courtyard in a small well-tended garden area. Patients could smoke in the shelter and were offered support with smoking cessation if accepted. There were three separate lounges, one for women, one for men and one mixed. There was a pool table in another room. The kitchen which was open for patients to make drinks had been recently refurbished. The female bathroom was out of order, and staff said they would find out if all repairs were completed.

There was a seclusion room away from the main ward area but it did not have shower facilities.

How we completed this review:

We looked around the ward and introduced ourselves to some patients. We met with one patient in private, talked to the staff and looked at five patient records.

What people told us:

One patient told us that the ward was very noisy. They said they felt unsafe at times on the ward. They said that staffing levels for the past two days meant that they were unable to go on escorted home leave and were not confident that leave would take place the day after our visit. They said there were no activities on the ward and described their stay as their worst experience of being in hospital.

Staff told us that they were managing some complex risky behaviour by patients at present. They expressed concern about the impact on other patients as the ward was very noisy at times, even during the night.

Staff said that they worked well together as a team. They all took part in fortnightly reflective practice sessions with psychology as well as fortnightly formulation groups. They said that the multi-disciplinary meetings were no longer led by the responsible clinician and that all professionals including pharmacy, occupational therapy (OT) and psychology took part. Staff prepared patients and carers prior to meetings to work out what they wanted to say and to encourage them to speak for themselves if possible. They held reception meetings with carers as soon as possible following a patient's admission and directed carers to Rethink for support and assessments of their needs.

Staff told us that they had done a lot of work around safer wards, including a comfort box, "knowing me, knowing you" sessions where staff and patients shared neutral information about themselves such as hobbies or favourite films and a discharge tree where patients who left could post messages about recovery for others. A team day was planned where each member of staff would present one area of safer wards work.

Staff said that supervision and appraisals happened regularly and they were able to undertake training. Healthcare staff undertook national vocational qualifications (NVQs) and were offered posts as apprentices until this was completed. We were told that some staff had undertaken dual diagnosis training which had proved very helpful. Specialist dual diagnosis staff also attended the ward to help with any issues and to work with their patients during admissions. The ward also admitted people with personality disorder on a 72 hour care pathway. Staff said they were not confident that this worked in practice.

Past actions identified:

On our last visit in October 2014 we found little evidence that patients were offered a range of therapeutic activities on the ward. We asked how the trust would ensure that a range of meaningful, therapeutic activities was offered to patients on Mill View Court during the recruitment process to the OT post and the activities coordinator post.
On this visit we found that appointments had been made to both posts in recent months and that work was under way to develop an activities programme.

We also asked a year ago why the ward did not hold community meetings. The trust replied that it planned to introduce mutual respect meetings.
On this visit we were told that these were held daily. However the activities coordinator planned to start weekly community meetings which would be minuted with the minutes displayed on the ward.

On our last visit we found that section 17 leave had been cancelled on at least one occasion due to staffing issues. The trust told us that it would audit leave cancellations and recruit staff to vacancies.
We found on this visit that all vacancies had been filled. However we found that it was not always possible to facilitate leave.

On our last visit one patient was waiting to go to a specialist facility to receive care and treatment that was not available in Hull. Staff were unclear about the process and reasons for delays.
This was resolved, and staff told us on this visit that they were now clear about the process. They told us of a recent situation where the process of accessing funding for a patient to move to a specialist placement had worked well.

Domain areas

Purpose, respect, participation and least restriction:

We observed that staff treated patients with courtesy and respect during our visit. We saw comprehensive assessments and evidence of the patients' views and participation in care planning on the patient notes that we reviewed. One patient said that no-one had told them that their medication had changed or explained how that might affect them. They said they were refusing to take their new medication as a result. They said that staff had not worked with them to meet the goals in their original recovery star. They felt let down.

One patient told us there was nothing to do on the ward. Staff said that they had tried to provide some activities over the past year and were confident that more would be offered soon with the appointment of the activities coordinator as well as the OT. The activities coordinator told us that she planned to work occasional weekends and evenings and worked with healthcare assistants to enhance their confidence in leading activities. The manager hoped to make more activities time available to ensure seven day coverage.

The walls of the corridor displayed a range of information about the services such as the recovery star model, patients' rights, the advocacy service, photos of staff, and safer wards.

Admission to the ward:

We found that there were two different spellings of a patient's surname on one section 3 application form. This mistake had not been picked up on admission or in scrutiny processes. Staff informed the mental health act legislation department during our visit so that action could be taken.

We found that staff undertook comprehensive assessments of a patient's needs on admission and involved carers where appropriate. Staff wrote full records for each shift about the patient's day and interactions. There were comprehensive records of the responsible clinician's (RC) meetings with patients.

We found that staff were giving patients section 132 information about their rights as detained patients on admission. However we found no evidence that this had been repeated to ensure that patients understood their rights.

Patients were given a leaflet about the independent mental health advocacy (IMHA) service and could refer themselves or ask staff to do so. Staff said that they referred patients who lacked capacity to make this decision.

Tribunals and hearings:

The domain area was not reviewed on this visit.

Leave of absence:

One patient raised issues about section 17 leave as outlined below. Section 17 leave forms were detailed and showed an expiry date. On one file overnight leave remained in place but the file indicated that it had been cancelled.

Transfers:

The domain area was not reviewed on this visit

Control and security:

Staff worked hard to keep the ward safe for all patients. However one patient told us they did not feel safe due to the behaviour of one patient who was also threatening towards staff. They said they spoke on behalf of other patients too. The patient disturbed other patients both day and night.

The extra care area and the seclusion room were away from the main ward area, thus protecting the dignity and privacy of a patient who needed to be secluded. We found that comprehensive records of seclusion episodes were made and that the required reviews took place in a timely and thorough way. A clock could be seen from the seclusion room, and it displayed the time, day and date. There was a toilet and washbasin which could be accessed from the extra care area but not directly from the seclusion room itself. There was no shower in the room, which could be problematic if a patient required a longer period of seclusion.

Consent to treatment:

The domain area was not reviewed on this visit

General healthcare:

We found that patients had physical healthcare assessments on admission and any health issues were followed up.

Other areas:
An OT was in post on this visit and the activities coordinator had just started. We acknowledged that the new coordinator would need time to develop a full programme as the post had been vacant for over a year. There was a board displaying some activities but there was no evidence of a full and varied programme which had input from patients about their choices. One patient said there was nothing to do on the ward and so spent most of their time in bed.

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 Admission to the ward	**CoP Ref:** Chapter 35

We found:
There were two different spellings of a patient's surname on the section 3 application form. This mistake had not been picked up on admission or in scrutiny processes. Staff informed the mental health act legislation department during our visit so that action could be taken and legal advice sought if necessary.
Your action statement should address:
What action was taken concerning this error. What action hospital managers will take to ensure that scrutiny processes are in accordance with the Code of Practice chapter 35.12 which states: - "Documents should be scrutinised for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention..."

Domain 2 Admission to the ward	**CoP Ref:** Chapter 4

We found:

We found that staff were giving patients section 132 information about their rights as detained patients on admission. However we found no evidence that this had been repeated to ensure that patients understood their rights.

Your action statement should address:

What action you have taken to audit compliance with the Code of Practice chapter 4.28 which states:-

> 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 that is 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…

Domain 2 Leave of absence	**CoP Ref:** Chapter 27

We found:

On one file the form authorising section 17overnight leave remained in place but the file indicated that it had been cancelled.

Your action statement should address:

What action you have taken to ensure that section 17 leave forms that are no longer valid are deleted to avoid mistakes being made in line with the Code of Practice chapter 27.17 which states, “Responsible clinicians should regularly review any short term leave they authorise on this basis and amend it as necessary.”

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:	F

Issue:

The patient said that they did not feel safe on the ward particularly at night. They said that towels were hung over their bedroom door to avoid doors banging and disturbing other patients at night. This meant that the door could not be locked and they were afraid of one patient. The manager was not aware that towels were hung on doors and said this would be addressed. Also she said she would consider whether there were safeguarding issues for the patient during their stay and look at a safety plan.

The patient said that they had been unable to have two hours escorted section 17 leave to visit her home for two days due to staffing issues. They had been offered half an hour's leave in the local area instead. Although staff told them that they would try to ensure that they had two hours leave to go to their home the next day, the patient was not confident that this would happen. They needed to go home to collect mail and to check details for a hospital appointment the following week. They said that staff had written a recovery star without their input on admission but had not facilitated some of the goals. They said that their medication had been changed but no-one had discussed this with them. As a result they were refusing to take the medication.

They said this was their worst experience of a hospital stay including previous admissions to Mill View Court.

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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