Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Millview
Ward(s) visited:	Mill View Court
Ward types(s):	Acute ward for adults of working age
Type of visit:	Unannounced
Visit date:	11 January 2017
Visit reference:	37049
Date of issue:	02 February 2017
Date Provider Action Statement to be returned to CQC:	22 February 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Mill View Court is a mental health assessment and treatment facility with 10 beds for male and female patients. The unit is located in the grounds of Castle Hill General Hospital in Willerby on the outskirts of Hull.

There were ten patients on the day we visited. Two patients were detained under the Mental Health Act 1983 (MHA). There were eight informal patients. A third detained patient was on section 17 leave and was due back for potential discharge on the day of our visit. Another informal patient who had been detained was currently in Hull Royal Infirmary (HRI) for physical health assessment and treatment. A member of staff from Mill View Court was with them at all times and staff undertook daily reviews of their mental state.

On the day of our visit there were two registered nurses and two healthcare workers on duty in addition to the deputy charge nurse. One healthcare worker was at HRI with a patient. There were two further staff on “no patient contact” duties due to pregnancy. There was also an activities coordinator. The occupational therapist (OT) from another unit attended one day per week to provide partial cover for the post holder who was covering another unit. On the day of our visit junior medical staff were available, and the responsible clinician (RC) was in attendance for care reviews that afternoon.

How we completed this review:

This was a routine unannounced visit to the ward by a Mental Health Act Reviewer (MHAR). We introduced ourselves to detained and informal patients as we looked around the unit. Patient engagement forms were given to the two detained patients and they were offered private interviews. We received no completed patient engagement forms, and the two detained patients did not wish to see us in private. We met with staff informally and reviewed two patient files. We gave feedback to the deputy charge nurse at the end of the visit.

What people told us:

Patients told us they were very happy with their care on the unit. They said the staff treated them with respect and were very helpful at all times. They said there were plenty of activities both for individuals and for groups.

Staff told us they worked well together as a team and supported each other. They felt motivated in their work and supported by the charge nurse. However they thought the trust management team was remote with little contact with staff providing care. They thought communication about decisions was poor in the organisation.

They gave two examples. Staff found out from the local paper that one of the trust's rehabilitation units had closed at the end of 2016. Secondly they were unaware of a potential change of use for Mill View Court when staff from another service came to view the unit.

Staff said the seclusion suite had been taken out of service. There had been a discussion about how to deal with an incident which may have previously led to the use of seclusion. A flow chart describing how to find an alternative seclusion facility and transport was drawn up. However when staff had followed this they could not access transport that day. They said managers were looking at how to improve transport access. Staff were aware of the Code of Practice requirements and the trust's seclusion policy. They were clear that if they prevented a patient from leaving any room, they would follow the seclusion policy to ensure that the patient was safeguarded.

Past actions identified:

We undertook a Mental Health Act (MHA) monitoring visit to the unit on 20 October 2015 and raised a number of issues:

- There was an error in spelling of a patient's name on a section 3 application form which was not detected on admission or scrutiny. The trust acted to resolve the issue immediately and took steps to strengthen scrutiny processes to avoid future errors. We found no similar errors on mental health act documents on this visit.
- We found no evidence that section 132 information had been repeated following admission to ensure that patients understood their rights. On this visit this was no longer an issue. However the file indicated that prior to the patient's transfer, another unit within the trust had not repeated information following admission.
- There was a discrepancy between section 17 leave authorisation and a multi-disciplinary team decision. We found on this visit one patient's section 17 leave authorisation had not been renewed by the RC and yet the patient had had leave. We discuss this further below.

Domain areas

Protecting patients' rights and autonomy:

We found staff gave detained patients information as required by section 132 on admission to the unit and at regular intervals. We saw that both detained patients on the ward had been given support to access a mental health tribunal. Staff also ensured that informal patients were given information about their rights.

Information about rights for detained patients and the independent mental health advocacy (IMHA) service were on display in the corridor. Staff said they referred patients who did not have capacity to make the decision to instruct an IMHA.

There was a comprehensive range of information about a variety of topics on display in the corridors. This included local services, infection control, domestic violence, smoking cessation, activities on the unit, complaints and the role of the Care Quality Commission (CQC).

Patients could have access to their mobile phones. Staff told patients they could not use the phone camera on the unit. A poster on the corridor reminded patients about these restrictions. They could also use an electronic tablet provided by the unit to access the internet.

Assessment, transport and admission to hospital:

We found evidence on files that staff assessed patients' capacity repeatedly in reference to a range of issues. They held best interests meetings where appropriate and recorded outcomes. They made comprehensive records of discussions about the care plans at regular multi-disciplinary meetings, including alternatives to detention under the Mental Health Act.

Mental Health Act documents relating to the current period of detention were on both files we reviewed. However on one file there was no copy of section 2 documents preceding the section 3. At our request staff did locate copies which were in order, and we asked for the copies to be placed on file.

Additional considerations for specific patients:

We did not review this area on the day of our visit.

Care, support and treatment in hospital:

All patients had physical health assessments on admission. These were reviewed as required, and patients were referred for specialist physical healthcare where indicated.

The unit admitted both male and female patients. There were five male and five

female bedrooms on opposite sides of the main unit area. All bedrooms were ensuite and could be locked from the inside with a staff override facility. There was also a female only lounge. Staff told us they had procedures to follow when they had to accommodate patients of opposite genders on both sides of the bedroom area to ensure all patients were safeguarded. They said they reviewed bed occupancy regularly to limit the length of time gender separation was not achievable.

Patients who spoke to us talked in positive terms about their care and interaction with staff on the unit. They praised the high standards of maintenance and cleanliness on the unit.

The unit had two part time activities coordinators who worked shifts to provide input at weekends. The activity programme was flexible to accommodate patient requests, such as one for a knitting group on the day of our visit.

Staff told us they were looking to identify any restrictive practices. They had recently had a team session to look at these issues and developed a better understanding of seclusion procedures. They no longer had a seclusion room. That area was now a low stimulus environment. Staff had found de-escalation techniques very helpful in challenging situations. On one occasion when they decided they needed a patient to be held safely in a seclusion suite, they could not access transport. This matter had been raised with senior managers who were looking at how to improve transport access.

The files showed that care plans were regularly reviewed by the team with input from patients about their views and hopes. Carers were also invited to offer their views with the patients' agreement.

We found the RC made a brief one sentence note of their discussion with one patient to establish if they had capacity to consent to medication prior to the completion of a Form T2. A more comprehensive note of the discussion with the patient would evidence how the decision was reached; especially as it was noted elsewhere in the file the patient did not find their medication helpful.

Staff told us they had regular training on safeguarding issues and knew what action to take if they identified a safeguarding concern.

Leaving hospital:

We found evidence of discharge planning on the two files we reviewed. Multi-disciplinary meetings were fully recorded. Staff were working with one patient to accept a referral to rehabilitation services. They were considering residential options for a second patient and looking at what legal frameworks were needed in that situation.

We were concerned to find one patient's section 17 leave authorisation had expired on 4 January 2017. No reasons to cancel leave were noted in the care review, and the patient went on escorted leave with two staff on 5 January 2017. This leave was not authorised. The patient had no further leave, despite requesting it. They asked

staff for leave during a brief conversation with us. They were told by staff the RC would resolve this later that day. This patient had been deprived of section 17 leave opportunities for a week. We consider this to be an unacceptable delay, leave being part of preparation for discharge.
Professional responsibilities:
We did not review this area on the day of our visit.
Other areas:
The two files we reviewed were not in good order. Some pages were loose. One file had no copy of section 2 documents. Duplicate copies of some documents were held in various places on the files, making it difficult at times to follow the patients' journey.

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 **Leaving hospital**	**MHA section:** Section 17 **CoP Ref:** Chapter 27

We found:

One patient's section 17 leave authorisation had expired on 4 January 2017. No reasons to cancel leave were noted in the care review, and the patient went on escorted leave with two staff on 5 January 2017. This leave was not authorised. The patient had no further leave, despite requesting it. They asked staff f
or leave during a brief conversation with us. They were told by staff the RC would resolve this later that day. This patient had been deprived of section 17 leave opportunities for a week. We consider this to be an unacceptable delay, leave being part of preparation for discharge.

Your action statement should address:

What action you have taken to ensure all section 17 leave is authorised by the RC.

What action you have taken to ensure patients are not deprived of leave due to the RC not renewing leave where there were no reasons to cancel leave.

The Code of Practice paragraph 27.8 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 to anyone else. "

The Code of Practice paragraph 27.17 states: - "Responsible clinicians should regularly review any short term leave they authorise on this basis and amend it as necessary."

Domain 2 **Care, support and treatment in hospital**	**MHA section:** 58 **CoP Ref:** Chapter 25

We found:

We found the RC made a brief one sentence note of their discussion with one patient to establish if they had capacity to consent to medication prior to the completion of a Form T2. A more comprehensive note of the discussion with the patient would evidence how the decision was reached; especially as it was noted elsewhere in the file the patient did not find his medication helpful.

Your action statement should address:

What steps you have taken to ensure RCs make a full record of their discussion with a patient to establish their understanding of medication and capacity to consent prior to completion of a form T2.

The Code of Practice paragraph 25.17states:

> "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 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."

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
Author	Care Quality Commission
Audience	Providers
Copyright	

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