Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated Individual:	Jules Williams
Region:	North
Location name:	Willerby Hill
Location address:	Beverley Road, Willerby, Hull, Humberside. HU10 6ED
Ward(s) visited:	Humber Centre Forensic Unit: Ullswater
Type of visit:	Seclusion
Visit date:	1 December 2015
Visit reference:	35303
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Date Provider Action Statement to be returned to CQC:	11 January 2016

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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Seclusion and longer term segregation	
☒	Purpose, respect, participation and least restriction
☒	Control and security
☐	Consent to treatment
☒	General healthcare
☒	Patient experience
☒	Staff practice
☒	Governance
☒	Physical environment

Findings and areas for your action statement

Overall findings

Introduction:

This was an unannounced thematic review to examine the use of seclusion on Ullswater ward at the Humber Centre Forensic Unit. Ullswater was a 12 bedded medium secure unit for male patients with a learning disability. We were informed that only ten of the beds were operational and on the day of the visit there were eight patients allocated to the ward. All patients were detained under the Mental Health Act 1983 (MHA).

The ward was arranged around a secure courtyard area. There were a number of communal spaces available to patients on this ward which included a television lounge, two activity rooms, a rehabilitation kitchen and a relaxation room. En suite bedrooms and communal spaces were arranged in and amongst each other rather than having dedicated corridors for each. There were two seclusion rooms next door to each other at one end of the ward. The accessible bathroom was located next door to these. A second off ward bathroom was also available to patients as was an education room. We were informed that patients had access to a sports hall, gym and a further outside area.

One of the seclusion rooms was occupied by a patient who had been secluded for the past 23 months. A second patient from Ullswater ward was also subject to seclusion. He was being secluded on the adjacent ward (Swale) in order to protect his privacy and dignity. Observations and reviews for this patient were being provided by the care team on Swale ward.

On the day of the visit there were two qualified nurses (one on preceptorship) and four nursing assistants. The team was supported by two deputy managers and a ward manager.

How we completed this review:

This was an unannounced review to examine the use of seclusion on Ullswater which was undertaken by a Mental Health Act Reviewer and an Inspection Manager. We were shown around the ward and had the opportunity to inspect the vacant seclusion room and the “extra care” area. We met with both the secluded patients and had the opportunity to speak to the deputy ward manager and charge nurse. We reviewed the trust policy on seclusion and scrutinised the seclusion documentation for the patient secluded on Ullswater. We also had the opportunity to discuss our findings with the ward manager, modern matron and clinical care director.

What people told us:

We spoke to a number of staff on the ward who were open about their opinion of and use of the seclusion room and extra care area. They expressed concerns that the seclusion environment and arrangements did not meet the needs of the patient who was currently secluded there.

Staff told us that they needed support from individuals and agencies that specialised in autism. We were told that two days training on autism had recently been provided by the National Autistic Society around autism awareness. Staff told us that they needed more targeted training and advice on how to meet the specific needs of the secluded patient.

Staff expressed their frustration that attempts to transfer this patient to a more appropriate environment were not progressing. They did not feel that they were able to meet his needs and told us that individual staff members were finding this very stressful.

Past actions identified:

There were no past actions identified as this was our first review of seclusion on this ward.

Domain areas

Purpose, respect, participation and least restriction:

We reviewed the notes of the patient secluded on Ullswater ward. We found he had been admitted directly into seclusion where he had remained for 23 months. There was limited information available within the files about this patient's likes, routines, and means of expression. As this patient had a diagnosis of autism and had limited communication, it was difficult for him to express his needs directly. We were informed that the views of his carers were constantly sought and that the independent mental health advocate (IMHA) was involved and included in all meetings to discuss this patient's care and treatment.

The seclusion environment was not sufficient to meet the documented needs of this patient. For example providing a structured routine and enabling free access to outside spaces was not possible within the current arrangements. Concerns were expressed about the impact of the environment on this patient's behaviour. Specifically it was not clear how this patient's behaviour could improve within the seclusion environment and therefore it was not clear how seclusion could be brought to an end. There was no care plan in place to address this.

We were unable to find any evidence that attempts to create a structured routine were being tried for this patient. We could not find an activities plan within the patient notes and staff confirmed they offered ad hoc opportunities dependent on

the patient's presentation. We were told that this patient was supported to access the main ward when he wanted to, but this was infrequent as he found this difficult to tolerate. There did not appear to be any easy read or pictorial information in the seclusion area which would support the patient to orient himself to the routine of the day or give him the opportunity to consider what activities were available to him.

We were informed that this patient had some sensory needs and we noted that he was not wearing a top when we met with him. There was also reference to how the temperature could affect him in his notes. We were unable to find any reference to a sensory assessment having taken place or any care plan to address his sensory needs.

This patient was nursed in the seclusion room with the door open, although this would be closed when he asked for it or when his behaviour warranted it. He appeared to spend his time knelt on the seclusion mattress. This patient was not always willing to use the toilet facilities and would often wet himself. On the day of our visit the seclusion area smelt strongly of urine. We were told that it was difficult to persuade the patient to take a shower and that he was currently refusing to do so. It was also difficult for the staff to get into the seclusion room to clean it. In order to address this, a best interests meeting was held two weeks prior to our visit, but the minutes had not yet been ratified. As a result, this patient remained in an environment that smelled strongly of urine and staff were unable to physically intervene to clean either the room or the patient. There was no care plan in place to address this patient's personal care or physical cleaning of the environment.

Staff expressed concerns about the physical health of this patient because of the time he spent kneeling and the fact that he was kneeling in urine some of the time. We were informed that a best interests meeting had taken place in respect of his physical health. We learned that a detailed plan had been put in place following this for a doctor to examine and address his physical health needs.

Control and security:

We found evidence that the policy framework in place at the Humber Centre provided an appropriate balance between security and least restriction. We also found evidence that restraint and seclusion were only used where necessary and then as a last resort. We determined that there was a culture amongst staff which reflected the use of other less restrictive techniques to avoid restraint or seclusion. We found that one patient had been secluded following a very serious unprovoked assault against a member of staff and that a second patient was secluded because staff felt his behaviour could not be managed on the main ward.

We were told that staff had received appropriate training in the management of actual or potential aggression (MAPA).

Consent to treatment:

This domain was not reviewed on this visit. However, when reviewing the patient's notes we found evidence that the patient's capacity to consent to treatment was being assessed and documented in accordance with the Code of Practice.

General healthcare:

There were comprehensive arrangements in place to meet the physical healthcare needs of the main ward population. In respect of the patient secluded on Ullswater, we found that a best interests meeting was recently held and that following this, a detailed plan to physically examine the patient had now been put in place.

Seclusion

Patients experiences:

We met with both secluded patients. One patient told us that he was aware of the reasons he had been brought into seclusion and about plans to transfer him to a more appropriate service. He said that he had the opportunity to read his magazines and to listen to the music of his choice whilst in seclusion. He also told us that he had been able to speak with his family on the phone although said that this had not happened for a while. This patient confirmed that he understood the current arrangements and he did not require anything else. The other secluded patient was less able to communicate with us but we were able to observe the interactions between him and his care team. We saw that staff were able to understand what he was saying and that they were attempting to offer him reassurance that he could remain in seclusion. They explained to us later that it would be anxiety provoking for him if he felt he had to leave this environment.

Staff practice:

We examined the seclusion record for the patient on Ullswater. As this patient had been in seclusion for 23 months, the records were extensive and held in three different files. Due to the length of time that the patient had been subject to seclusion, we were informed that the MDT had agreed new review arrangements.

The patient was under 2:1 constant observation and these observations were recorded at least every 15 minutes as per the trust's seclusion policy. However, there appeared to be a deviation from the policy due to the length of time the patient had been secluded as nursing reviews were no longer happening and medical reviews were taking place every 24 hours.

The procedural safeguards required by the Code of Practice state that seclusion should be reviewed by two independent nurses every two hours and by a doctor at least twice in every 24 hour period following the first multi-disciplinary (MDT) review.

The Code of Practice paragraph 26.139 states that "…Further MDT reviews should take place once in every 24-hour period of continuous seclusion".

The Code requires less frequent monitoring of patients subject to longer term segregation but stipulates the added safeguard that "…regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital…" (paragraph 26.156). We were informed that the frequency of medical and multi-disciplinary (MDT) reviews had been agreed by the MDT, but we were unable to find where this had been documented. We were also unable to find evidence that the reviewing of this patient's seclusion met the requirements of either seclusion or longer term segregation as outlined in the Code of Practice.

Governance:

We examined the trust seclusion policy version 4.02 which was dated 2011 and was currently under review. The current policy did not take into account the requirements of the Code of Practice which was issued in April 2015. The trust did not have a longer term segregation policy despite having two patients in seclusion on this ward who would meet this definition. Reviews of their ongoing need for seclusion were agreed by the MDT and did not appear to meet the procedural safeguard requirements of the Code of Practice for either seclusion or longer term segregation.

We were told that seclusion reports would usually be provided to the operations management group for the monitoring of seclusion. However, due to the length of seclusion in both cases, the director of nursing had informed the wards to only provide reports if there were any changes.

Physical environment and facilities:

The seclusion rooms on Ullswater and Swale appeared to meet the requirements of paragraph 26.109 of the Code of Practice. Each seclusion room had an observation area and small ante room which could be used as an extra care area. There was comfortable seating in the anteroom next to the occupied seclusion facility on Ullswater. Each seclusion suite had adjacent toilet and showering facilities. We noted that whilst the seclusion rooms had relatively small observation panels, they contained parabolic mirrors and had CCTV to enable staff to fully observe the secluded patient. Temperature and lighting could be controlled from outside the seclusion room and there was a two way intercom to aid communication. Each seclusion room had a small hatch through which medication and food could be passed. The hatch was also opened to facilitate communication. A clock was brought into the observation area so that it could be seen by patients when the seclusion room was occupied.

On the day of the visit, the seclusion area on Ullswater smelled very strongly of urine. We also noted that the seclusion room walls had food or drink splattered in places. We were informed that staff were currently unable to physically intervene to clean up the room without the patient's consent.

Longer term segregation

Governance:

The trust did not have a policy for longer term segregation. As a result, the patient occupying the seclusion room on Ullswater was considered to be subject to seclusion despite the length of time he had remained segregated from other patients.

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.

Seclusion & longer term segregation Governance	**CoP Ref:** Chapter 26

We found:

The trust policy on seclusion was dated 2011 and was due for review in 2014. The current policy was out of date as it did not take account of the requirements of the Code of Practice which came into effect in April 2015. The trust did not have a policy for the longer term segregation of patients.

Your action statement should address:

The Code of Practice paragraph 26.110 states: “Provider policies should include detailed guidance on the use of seclusion and should be consistent with the guiding principles of the Code…”

Annex B of the Code of Practice details a list of policies which each trust should have in place. This states:

> Providers should have a policy on long-term segregation, which provides for periodic reviews by a senior professional who is not involved with the case, recording of the outcome of all reviews and the reasons for continued segregation, and reporting of outcomes to the responsible commissioner.

What action will be taken to ensure that all policies are consistent with the requirements of the Code of Practice.

How staff will be made aware of the requirements of the Code of Practice.

Seclusion & longer term segregation Staff practice	**CoP Ref:** Chapter 26

We found:

Whilst we were told that the arrangements for reviewing the patient's seclusion were agreed by the MDT, we were unable to locate where this was recorded. There was clear evidence available in the patient files that medical reviews were occurring once in every 24 hour period. However, we were unable to find evidence that the reviewing of this patient's seclusion met the requirements of either seclusion or longer term segregation as outlined in the Code of Practice

Your action statement should address:

In relation to seclusion, the Code of Practice paragraph 26.126 states:

> A series of review processes should be instigated when a patient is secluded. These include the multi-disciplinary team (MDT), nursing, medical and independent MDT reviews…

In relation to longer term segregation, the Code of Practice paragraph 26.155 states:

> The patient's situation should be formally reviewed by an approved clinician who may or not be a doctor at least once in any 24-hour period and at least weekly by the full MDT. The composition of the MDT should be decided by the provider's policy on long-term segregation, but should include the patient's responsible clinician and an IMHA where appropriate. Provider's policies should provide for periodic reviews by a senior professional who is not involved with the case. The outcome of all reviews and the reasons for continued segregation should be recorded and the responsible commissioning authority should be informed of the outcome).

And at paragraph 26.156

> Where long-term segregation continues for three months or longer, regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital. This should include discussion with the patient's IMHA (where appropriate) and commissioner.

What action the trust will take to ensure that seclusion is reviewed in accordance with the requirements of the Code of Practice.

How the arrangements of the reviewing of seclusion will be recorded within the seclusion documentation.

Seclusion & longer term segregation Staff practice	**CoP Ref:** Chapter 26

We found:

The medical review documentation referred to “continue with plan”, but we were unable to find where the seclusion plan was recorded and staff were unable to source this for us.

Your action statement should address:

The Code of practice paragraph 26.147 states:

> A seclusion care plan should set out how the individual care needs of the patient will be met whilst the patient is in seclusion and record the steps that should be taken in order to bring the need for seclusion to an end as quickly as possible. As a minimum the seclusion care plan should include:
>
> - a statement of clinical needs (including any physical or mental health problems), risks and treatment objectives
> - a plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed
> - details of bedding and clothing to be provided
> - details as to how the patient’s dietary needs are to be provided for, and
> - details of any family or carer contact/communication which will maintained during the period of seclusion in accordance with paragraph 26.16.

What action will be taken to ensure that a seclusion plan is in place for all secluded patients, that it is accessible and that all staff involved in the care of secluded patients are aware of the content.

Seclusion & longer term segregation Purpose, Respect, Participation, Least Restriction	**CoP Ref:** Chapters 1 & 26

We found:

The seclusion environment was not sufficient to meet the documented needs of this patient. For example providing a structured routine and enabling free access to outside spaces was not possible within the current arrangements. Concerns were expressed about the impact of the environment on this patient's behaviour. Specifically it was not clear how this patient's behaviour could improve within the seclusion environment and therefore it was not clear how seclusion could be brought to an end. There was no care plan in place to address this.

Your action statement should address:

The Code of practice paragraph 1.16 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…

The Code of Practice 26.148 states:

> Wherever possible, the patient should be supported to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for the seclusion to come to an end. In view of the potentially traumatising effect of seclusion, care plans should provide details of the support that will be provided when the seclusion comes to an end.

What action will be taken to ensure that this patient is nursed in a therapeutic environment that supports recovery.

How the known needs and wishes of the patient will be incorporated into a care plan whilst he remains in seclusion.

What actions will be taken in order to reduce the level of restrictions this patient is currently subject to.

Seclusion & longer term segregation Physical environment and facilities	**CoP Ref:** Chapter 1

We found:

This patient was being nursed in an environment that smelled strongly of urine and staff were unable to physically intervene to clean either the room or the patient. The minutes from the best interests meeting held two weeks ago had not been ratified. There was no care plan in place to address this patient's personal care or physical cleaning of the environment.

Your action statement should address:

The Code of Practice paragraph 1.13 states: "Patients and carers should be treated with respect and dignity. Practitioners performing functions under the Act should respect the rights and dignity of patients and their carers, while also ensuring their safety and that of others."

How the personal care needs of this patient will be met whilst he remains in seclusion in a way which is respectful and promotes dignity.

Seclusion & longer term segregation Purpose, Respect, Participation, Least Restriction	**CoP Ref:** Chapter 1

We found:

We were unable to find any evidence that attempts to create a structured routine were being tried for this patient. We could not find an activities plan within the patient notes and staff confirmed they offered ad hoc opportunities dependent on the patient's presentation. There did not appear to be any easy read or pictorial information in the seclusion area which would support the patient to orient himself to the routine of the day or give him the opportunity to consider what activities were available to him.

Your action statement should address:

The Code of Practice paragraph 1.15 states:

> Care, support and treatment given under the Act should be given in accordance with up-to-date national guidance and/or current best practice from professional bodies, where this is available. Treatment should address an individual patient's needs, taking account of their circumstances and preferences where appropriate.

What actions will be taken to ensure that this patient is offered care and treatment that will support his recovery and bring his seclusion to an end in accordance with national guidance and best practice.

During our visit, no patients raised specific issues regarding their care, treatment and human rights.

Information for the reader

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Audience	Providers
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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