Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Townend Court, 298 Cottingham Road, Hull, Humberside HU6 8QR
Ward(s) visited:	Beech
Ward types(s):	Ward for people with learning disability or autism
Type of visit:	Unannounced
Visit date:	16 August 2016
Visit reference:	36546
Date of issue:	21 September 2016
Date Provider Action Statement to be returned to CQC:	11 October 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 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Beech is a male rehabilitation ward for people with a learning disability or autism. It is part of Townend Court, which has two other wards, which are used for admission and assessment. Beech ward opened towards the end of 2015. The ward had six beds. On the day of our visit there were six patients admitted to the ward, four patients were detained under the Mental Health Act 1983 (MHA) and two patients were under Deprivation of Liberty safeguards (DoLs) authorisations.

The ward was accessed from the main reception in the hospital through a locked door. The ward was a down a long a corridor. On entering the ward off the corridor was a dining room and main lounge area which had a television. There was access to a laundry and a clinic which was locked. The nurses' station did not have clear lines of site for the ward. However, staff told us this was not a concern due to patients being at the rehabilitation stage of their care pathway. We observed the nurses station door to always be open when staff were present in the office and not on the phone. We observed patients attending the nurses station to make their needs known. The ward had a kitchen which was locked and patients required staff to be able to access this to make a hot or cold drink. There was a smaller lounge with a television and music system. From the small lounge there was direct access to the outside garden and smoke shelter which patients were able to freely access. Bedrooms were located at the end of the corridor and contained an en-suite wet room. Patients were able to personalise their bedrooms. There were posters displayed around the ward made by patients with times for activities, for example a coffee morning .

We were told the baseline staffing for the ward was one qualified staff nurse and one healthcare assistant (HCA). We were told the day shift ran from 8am to 8.15pm. We were told nightshifts ran from 8pm to 8.15am. We were told the ward does not use agency staff but does use bank staff when required. There is a centralised bank staffing system. We were told there is always a permanent member of staff on duty who knows the ward. We were advised the ward always runs with two staff on duty and sometimes three. On the day of our visit the ward had one qualified staff nurse on duty and one HCA. There was a visiting activities coordinator who worked across all wards at Townend Court who visited the ward during our visit.

Medical cover was provided by a consultant psychiatrist and junior doctor. On the day of the visit the responsible clinician (RC) was in ward reviews.

How we completed this review:

We made a scheduled unannounced visit to the ward. We were shown around the ward by the nurse in charge. Two patients also showed us their bedrooms. We met with four patients and one patient spoke to us informally. We interviewed the nurse in charge. We met with health care assistants (HCAs), the activities coordinator, the responsible clinician (RC), the unit manager and staff nurses. We reviewed all six sets of patients' records.

We provided verbal feedback at the end of the visit to the unit manager, RC and junior doctor.

What people told us:

Patients spent time in the lounges, their bedrooms and engaging in activities. We observed patients being able to access fresh air in the garden at all times.

Patients spoke positively about the ward and staff, saying:

"plenty to do here"
"nice place this"
"ward is okay"
"staff are great, best place I have ever been"
"staff deserve a pay rise"
"peers are excellent"

Staff told us that they enjoyed working on the ward. Staff told us it could be challenging at times but that they enjoyed this.

Domain areas

Protecting patients' rights and autonomy:

We found evidence of patients being informed of their rights, including their right to access an independent mental health advocate (IMHA). We found one patient required their section 132 rights re-reading. We found that the form which indicated what information patients had been given regarding legal representation, in several cases was either left blank or ticked 'no'. This indicated that ward staff had not shared information about legal representation.

We observed a poster displayed about IMHA. Staff confirmed they would refer patients to an IMHA and an independent mental capacity advocate (IMCA) where appropriate. We found record of this happening in the patient's files. We were told by staff there was timely access to advocacy for patients.

We were unable to find record of patients having a community meeting; we were told they have a coffee morning. It was difficult to see the level of patient engagement in changes to the ward. We were told patients had access to their own mobile phone on the ward which was confirmed to us when we spoke to patients. Staff told us this was risk assessed. Patients were unable to have personal access to the internet on the ward. However, we were told Wi-Fi had recently been installed and that patients could use that to access internet on their mobile phones.

We found patients were able to have access to their bedroom at any time and to the outside garden area. We found the kitchen was locked and patients required staff to open the kitchen to enable them to make a hot/cold drink. This was a blanket restriction which had not been individually risk assessed and not in line with the Code of Practice (2015).

The ward displayed patients' art and craft. Patients were able to personalise their bedrooms. Two patients showed us their bedrooms which were personalised. Patients had their name outside of their room and were able to personalise the sign for their bedroom. We found all the areas on the ward had pictorial signs outside of the rooms to show what the purpose of the room was.

We were told that family and friends were encouraged to visit patients, and that visiting times were flexible. We were told visits could take place off the ward if the patient had section 17 leave or on the ward in the garden and lounge areas.

We looked at all of the care plans for the four detained patients. We found care plans to be individualised and that the patients' views were represented within them. Patients were encouraged to sign care plans and have a copy and we saw evidence of this. We found it difficult to see evidence of how patients and their family/friends were involved in the care plan reviews. We saw that risk assessments completed and they were up to date. On the day of the visit we saw recovery work taking place

on the ward which included a mindfulness group and baking. We saw timetables set out for the week to cover different activities such as arts and crafts, bowling and social events. Patients confirmed these activities take place and told us there was always plenty to do. We found record of discharge planning occurring following admission.

Throughout the visit we observed positive staff and patient interaction. We heard alarms being activated during our visit when a patient became unsettled from another ward. We observed staff to be responsive to the alarms.

Assessment, transport and admission to hospital:

Detention documents were available for scrutiny. This documentation contained the legal criteria for detention. We found approved mental health professional (AMHP) reports available in the files for the patients that were detained.

We were told patients usually transferred onto the ward from the assessment wards within Townend Court. However, we were also told patients could be admitted directly onto Beech ward if this was considered appropriate.

Additional considerations for specific patients:

Staff told us that they had done mandatory training which included training on learning disabilities and autism. We were told that staff made a request if they wished to do more advanced training in this area and that this was responded to. We were told updated training on the MHA was due to take place later in the month.

Care, support and treatment in hospital:

We found all patients whose records that we checked were being treated under the appropriate authority. We found that T2 and T3 certificates were with the medication cards when they were required.

Neither staff nor patients highlighted any difficulties regarding patients' physical healthcare needs being met. We were told by staff that patients on admission had their physical health screened and were referred for specialist input if required. We were told patients remained with their registered General Practitioner (GP) but were told out of area patients were temporarily registered with the local GP. We were unable to locate physical health checks for three patients. Staff told us this was recorded on the electronic recording system.

We observed the Speech and Language Therapist (SALT) attend the ward during our visit to see a patient. We also observed a social worker attend the ward to meet with a patient and family to discuss supported housing options.

The ward did not have seclusion facilities. We were told there was access to seclusion on a neighbouring ward. Staff told us that they had not needed to use seclusion to date and would consider a patient moving to an assessment ward if they required seclusion. We were told by staff that they de-escalate situations and

as a last resort would remove the patient from the area in the least restrictive way possible. Staff told us in these times they would support the patient to their room. We were told bedrooms were not used to seclude patients.

Leaving hospital:

Four patients' records who were detained under the MHA were checked. Three had escorted section 17 leave in place. We found leave to be authorised through a standardised system and recorded specified conditions. We found patients were offered copies of their leave and had signed them. We found care plans demonstrated evidence of discharge planning with relevant input from people involved in the patients care. We found copies of old section 17 leave forms on patient's records that had not been cancelled or struck through. We were told leave was discussed in the weekly ward round and we found record of this.

Professional responsibilities:

There was evidence of tribunals and hospital manager's hearings taking place for patients who had been on the ward.

There was evidence of systems in place to scrutinise documents when patients were admitted and systems in place to remind professionals when sections were due to expire.

Other areas:

We reviewed the deprivation of liberty safeguards (DoLS) paperwork for the two patients who were under DoLS authorisations. We found a lack of recording in the progress notes. For both patients we found the urgent authorisations had expired and we were unable to locate record if this been chased up. Staff contacted the Mental Health Act legislation team who confirmed they had chased this up with the responsible authority.

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:** **CoP Ref:** Chapter 8
We found:	
We found the kitchen to be locked and patients required staff to open the kitchen to enable them to make a hot/cold drink. This is a blanket restriction which has not been individually risk assessed and not in line with the Code of Practice (2015).	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (CoP) paragraphs: 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. 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 **Protecting patients' rights and autonomy**	**MHA section:** **CoP Ref:** Chapter 1

We found:

No community meetings in place that allowed patients to be involved in decisions about the ward.

Your action statement should address:

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

> 1.10 Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision making and any such assistance or support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them.

Domain 2 **Leaving hospital**	**MHA section:** 17 **CoP Ref:** Chapter 27

We found:

We found copies of old section 17 leave forms on patient's records that had not been cancelled or struck through.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (CoP) 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)).

Domain 2 Protecting patients' rights and autonomy	MHA section: 132 CoP Ref: Chapter 4

We found:

We found one patient required their section 132 rights re-reading. We found for several of the patients when they had, had their rights read the form which indicated what information they had been given regarding legal representation was either left blank or ticked no to indicate no information had been shared about legal representation.

Your action statement should address:

How you will demonstrate adherence with CoP 4.28 which states:

> 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 Care, support and treatment in hospital	MHA section: CoP Ref: Chapter 1 and 24
We found:	
We were unable to locate that physical health checks had been undertaken for three patients.	
Your action statement should address:	
How you will demonstrate adherence with CoP 1.17 and 24.57 which states: 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 Protecting patient rights and autonomy	**MHA section:** **CoP Ref:** Chapter 13

We found:

We reviewed the deprivation of liberty safeguards (DoLS) paperwork for the two patients who were under DoLS authorisations. We found a lack of records regarding the DoLS in the progress notes. For both patients we found the urgent authorisations had expired and were unable to locate record of this been chased up. Staff contacted the mental health act legislation team who confirmed they had chased this up with the responsible authority.

Your action statement should address:

How you will demonstrate adherence with CoP 13.60 which states:

> 13.60 In the relatively small number of cases where detention under the Act and a DoLS authorisation or Court of Protection order are available, this Code of Practice does not seek to preferentially orientate the decision-maker in any given direction. Such a decision should always be made depending on the unique circumstances of each case. Clearly recording the reasons for the final decision made will be important. The most pressing concern should always be that if an individual lacks capacity to consent to the matter in question and is deprived of their liberty they should receive the safeguards afforded under either the Act or through a DoLS authorisation or a Court of Protection order.

Information for the reader

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