Care Quality Commission

Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Miranda House
Ward(s) visited:	Avondale
Ward types(s):	Acute ward for adults of working age
Type of visit:	Unannounced
Visit date:	27 June 2016
Visit reference:	36259
Date of issue:	13 July 2016
Date Provider Action Statement to be returned to CQC:	2 August 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Avondale is a 14 bedded acute admission unit for male and female adults. It is located at Miranda House in Hull. Patients are admitted from Hull and the East Riding of Yorkshire.

On the day of the visit, 15 patients were being cared for on the unit. Seven patients were detained under the Mental Health Act (MHA). Single rooms were provided for all patients, some of them were fitted with ensuite facilities. Additional toilet and bathroom facilities were provided. Patients had access to a garden area. Smoking was allowed in this area.

There were five nursing staff on duty on the day of our visit, three qualified staff, including the charge nurse, and two health care assistants. In addition, one student nurse and an activities co-ordinator were on the unit.

How we completed this review:

During our visit we met and spoke with two patients. We also spoke with medical, nursing and social work staff.

We attended the morning meeting of clinical and social care staff, to observe how clinical care was reviewed.

We observed the unit environment and patient interactions with staff. We toured the unit accompanied by the charge nurse and spoke to some patients informally. We reviewed a sample of clinical records, care plans, assessments and Mental Health Act documentation. One patient completed a patient engagement form indicating how that person felt about their care and treatment.

We fed back to the charge nurse at the end of the day.

What people told us:

One patient told us, "the staff are spot on. I have no issues with the staff."

Another patient we spoke with felt the unit was "OK". This person completed a patient engagement form for us and had concerns about care planning and information on rights. This patient felt that staff communicated with him well and the food was satisfactory.

We talked with the charge nurse. She told us that patients known to the service with packages of care have a CPA (care programme approach) meeting within 48 to 72

hours of admission. Patients who are new to the service have a CPA meeting within five days of admission.

We were told that the unit manages patient admissions and assessments from across the district and that the length of stay can be approximately seven days. Patient may then be transferred to other units in other parts of the city for continuing treatment.

We discussed the issues raised on previous visits and how these had been addressed since that visit. These issues are reported on later in this report.

Past actions identified:

The last inspection took place on 3 November 2014 and the following concerns were raised on that visit.

- The unit was locked and all patients, including any informal patients, were required to ask staff before leaving the unit. Patients were not able to access some of the garden areas without staff escort.

  These concerns had been partially addressed. We were advised that informal patients were told they could leave the unit when they wanted and still needed to ask staff before leaving the unit. Information sheets for informal patients were available.

- The post of occupational therapist (OT) was vacant. An activities co-ordinator had recently been appointed.

  These concerns had been partially addressed. Since the previous visit an OT had been appointed, but was currently on secondment. The unit can refer to the OT on the psychiatric intensive care unit (PICU) for patient assessments and devising activity plans. We also noted the activities co-ordinator was working on the unit. We were given to understand there were plans to appoint another activities co-ordinator in order to provide cover seven days a week.

- There was little evidence of the patients' participation in the care plans we reviewed.

  These concerns had been partially addressed. We were told and saw in case files that recovery stars were being introduced and completed with patients. We also evidence in care plans that attempts were being made to involve patients in the care planning process. In addition, patients were participating in CPA (care programme approach) meetings. In the three files we reviewed, two of patients were not engaging fully with the treatment process.

- The seclusion room was adjacent to the low stimulus room. The seclusion

room did not have en-suite toilet and shower facilities. These were provided in the low stimulus room.

These concerns were still present. If patients were acutely unwell they had to use disposable containers for their toilet needs in a seclusion room with a glass fronted door. We were told there might be situations following appropriate risk assessment where a patient may be escorted from the seclusion room into the adjacent low stimulus room to use the bathroom facilities there. We have concerns about how the balance between a patient's dignity and safety were maintained in these circumstances.

It was disappointing to find that the trust had not taken steps to address this issue following our previous visit. We understand that this matter was also raised following the recent CQC comprehensive inspection. We would expect the trust to review how it adheres to the MHA Code of Practice guidance on seclusion facilities and adherence to Department of Health "best practice" guidance notes in regard to seclusion suite facilities.

Used disposable urine containers had been left in the seclusion room.

This concern appeared to have been fully addressed and a protocol had been agreed between Avondale and the PICU (psychiatric intensive care unit) to manage the cleanliness of the seclusion room.

- One patient raised a written list of concerns regarding cleanliness and an issue with one member of staff's attitude.

These concerns were fully addressed immediately following the previous visit.

Domain areas

Protecting patients' rights and autonomy:

There was an independent mental health advocacy (IMHA) service provided by Cloverleaf. We were told that the IMHAs visit the unit two or three times a week. We saw that information leaflets about the IMHA service were available at the entrance to the unit and on the patients' notice board.

We were advised by the charge nurse that automatic referrals were made to the IMHA service for patients who lacked capacity to make their own decisions about contacting the IMHA service.

The unit was locked. We were advised that informal patients were told that they need to talk to a member of staff before leaving the unit. There was no notice at the unit entrance advising informal patients about leaving the unit. We were told that these kind of notices tended to get ripped off the door. We suggested that it should be replaced so that advice on leaving the unit was available.

Patients could use their own mobile phones on the unit and could bring in laptop computers. Patients were advised that the use of camera phones were prohibited.

Smoking was allowed in the large garden area and a smoking shelter was available. We were told that there were plans to introduce a blanket ban on smoking in line with legislative requirements.

We saw in the three patient records we reviewed that patients consent was sought to share information with carers. In addition we noted the carers' information board, which contained a range of advice for carers. The trust also facilitated carers meetings.

In each patient record there was evidence of attempts being made to advise patients about their rights. A record was kept indicating whether or not a patient understood the information being explained to them.

Assessment, transport and admission to hospital:

We were advised by the charge nurse that staff had access to training about the Mental Capacity Act (MCA).

We sat in on the clinicians' morning meeting and noted that discussion took place about whether certain patients had capacity to consent to treatment.

In reviewing three patients' case files, it was difficult to find evidence in the clinical notes that consent was being sought from patients to treat them or that patients' capacity to consent was being assessed in line with the MCA test of capacity.

Additional considerations for specific patients:

This domain was not reviewed on this visit.

Care, support and treatment in hospital:

We reviewed three patients' care plans, risk assessments and progress notes. We found that these were satisfactory. They appeared to be comprehensive, up to date and reflected the needs of the patients. Interventions and treatment plans appeared to be appropriate and responsive to the patients' conditions.

Patients' general health care was assessed on admission using the health improvement programme part 1 (HIP1) documentation. Every patient had an electrocardiogram (ECG).

In two of the three patients' records we reviewed the HIP1 had been completed. One patient was refusing to co-operate with having a physical health check-up.

Leaving hospital:

We were only able to review one leave of absence record. The leave form appeared to have been fully completed by the responsible clinician (RC) and leave had been granted to attend for emergency care at the nearby general hospital. Conditions for leave had been set out by the RC.
Professional responsibilities:
We were able to review the detention papers for three patients. The applications for detention and medical recommendations all appeared to comply with legislative requirements. Each file contained a checklist for receiving the documentation and these were fully completed. We noted that patients were advised of their rights to apply for a tribunal and a hospital managers' panel hearing. We were shown the seclusion suite and low stimulus area, which was on a corridor away from the main patient area. The seclusion room complied with most of the guidance set out in the MHA Code of Practice in regard to observation, heating, light and furnishing. We noted earlier in this report that we had concerns about the lack of en suite bathroom facilities attached to the seclusion suite. We were told there might be situations following appropriate risk assessment that a patient may be escorted from the seclusion room into the adjacent low stimulus room to use the bathroom facilities there. Alternatively, patients were given urinals to use in the seclusion room. It appeared to us that patients' dignity and safety was compromised in the prevailing circumstances.
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 **Assessment, transport and admission to hospital**	**MHA section:** 58 **CoP Ref:** Chapter 24
We found:	
It was difficult to find evidence in the clinical notes that consent was being sought from patients to treat them.	
Your action statement should address:	
How the trust will ensure that clinicians act in accordance with 24.40 and 24.41 of the MHA CoP which state: "To give time to develop a treatment programme suitable for the patient's needs, the Act allows treatment to be given in the initial three month period starting the day on which any form of medication for mental disorder was first administered to the patient during the current period in which the patient is liable to be detained under the Act." And "During this time, the patient's consent should still be sought before any medication is administered, wherever practicable. The patient's consent, refusal to consent, or a lack of capacity to give consent should be recorded in the case notes. If a person has capacity to consent, but such consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment."	

Domain 2 **Assessment, transport and admission to hospital**	**MHA section:** 58 **CoP Ref:** Chapter 13
We found:	
We could not find evidence that patients' capacity to consent was being assessed in line with the MCA test of capacity.	
Your action statement should address:	
How the trust will ensure that clinicians act in accordance with 13.21 of the MHA CoP which states:	

"As capacity relates to specific matters and can change over time, capacity should be reassessed as appropriate over time and in respect of specific treatment decisions. Decision-makers should note that the MCA test of capacity should be used whenever assessing a patient's capacity to consent for the purposes of the Act (including, for instance, under section 58 of the Act)."

Domain 2 **Professional responsibilities**	**MHA section:** Other **CoP Ref:** Chapter 1c

We found:

We continue to have concerns about the lack of en suite bathroom facilities attached to the seclusion suite and how the balance between a patients' dignity and safety can be maintained in these circumstances.

Your action statement should address:

How the trust will ensure it acts in accordance with 26.109 of the MHA CoP which states that, "The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out…rooms should have access to toilet and washing facilities."

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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