Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hillary Gledhill
Region:	North
Location name:	Willerby Hill
Ward(s) visited:	Swale Unit
Ward types(s):	Medium Secure
Type of visit:	Unannounced
Visit date:	7 September 2017
Visit reference:	38076
Date of issue:	14 September 2017
Date Provider Action Statement to be returned to CQC:	04 October 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Swale ward is a 15 bed male medium secure ward for patients with a diagnosis of personality disorder located in the Humber Centre on the outskirts of Hull.

On the day of our visit there were 14 patients allocated to the ward. Two other additional patients had been transferred to South West Lodge located near the Humber Centre as a step down but remained under the care of the responsible clinician (RC), and nurses from the ward visited them. All patients were detained under the Mental Health Act 1983 (MHA).

Since our last visit to the ward, the ward had been separated into two parts, an assessment side and treatment side. Patients and staff appeared positive about this change. There were now six beds located on the assessment side of the ward and nine beds on the treatment side of the ward. Patients had access to a single bedroom with en suite washing facilities. All bedrooms had a lockable drawer and under bed storage. Both sides of the ward had a communal lounge. Both sides of the ward shared the secure garden area. There were two kitchens, one located on each side of the ward. Off the unit there was access to a visitors' room, a multi-faith room and a computer.

The staff worked 12 hour shifts on the ward. On the day of our visit there were two qualified nurses on duty and four healthcare assistants. In addition to this there was a band six nurse and ward manager. The ward manager told us the minimum staffing for the ward was six staff to include two qualified nurses. On a night shift the minimum staff numbers were three staff to include one qualified nurse.

The ward manager confirmed that agency and bank staff had been used regularly in recent months due to short staffing and some staff vacancies on the ward that were being recruited to. The ward manager told us there were three staff nurses due to start on the ward this month, two of these qualified nurses would be on preceptorship and one was an experienced nurse returning back to work on the ward.

One RC was responsible for the patients on the ward. The ward had some occupational therapy (OT) and psychology input. Other professionals inputted onto the ward where required.

How we completed this review:

This was a scheduled unannounced visit to the ward by a Mental Health Act Reviewer. On arrival we were met by the ward manager and modern matron. We had a tour of the ward by the ward manager and introduced ourselves to patients.

We met with seven patients detained under the MHA in private. All other patients declined to meet with us. We reviewed two patient's records and one episode of seclusion.

We gave verbal feedback to the ward manager, modern matron and band six nurse at the end of our visit.

What people told us:

Patients spoke to us about staffing on the ward and a number of patients told us that the ward was regularly short staffed "staffing levels are garbage", "there's only four qualified nurses for the ward at the moment", "staffing bad at times" and "regularly short staffed". Patients recognised that staff tried to facilitate all of their requests so that it would not impact on their care and treatment.

We asked patients about staff on the ward and were told, "some of the healthcare are loud and noisy", "two or three staff are alright the rest are morons", "some staff are flippant, sarcastic and in your face, but staff are 100 times better than the old staff. The ward has been turned around", "the staff are very good and friendly", "most of the staff are approachable but they talk to you like shit sometimes" and "a lot of staff who have left recently were the ones that would spend more time with you".

Various patients on the ward told us that they felt the food was repetitive as it was on a three week cycle. One patient told us they felt the food was "fantastic".

We asked the patients we met if they felt safe on the ward and were told, "only feel safe when a certain patient is in his room", "staff are not always present in the activities room and don't always feel safe on the ward", "don't feel safe on the ward, there's a lot of racism on the ward" and "feel unsafe at times".

Staff we met did explain that staffing on the ward could be a challenge at times due to short staffing. The ward manager told us that staff worked hard to ensure that short staffing levels on the ward did not impact on patient care often working additional shifts and at times not taking breaks or postponing breaks in the day time to ensure patient needs such as leave were met.

Past actions identified:

The last MHA monitoring visit took place on the ward on 11 January 2016. The following issues were identified;

- Assessment of capacity to consent to treatment was not completed for one detained patient in accordance with Code of Practice guidance.

We found this issue to be resolved on the records we reviewed.

- Two leave authorisations were not signed and completed to indicate that a

member of staff had given a copy of the leave authorisation to the patient or recorded the reasons for not providing a copy of the leave form.

We found this issue to be resolved on the records we reviewed.

- That some of the notices intended as information for patients were written in complicated and official language and provided no explanation for the rules and regulations laid out in them.

We found this issue to be resolved on the day of our visit.

Domain areas

Protecting patients' rights and autonomy:

There was a patient pay phone located within the assessment area of the ward. There was no patient pay phone located on the treatment side of the ward but the manager had requested quotes for the cost of putting this in. Patients did not raise this as a concern. The ward manager told us that they were in the process of issuing all patients on the ward a basic mobile phone as patients had raised issues of feeling that the payphone location on the ward was not very private. As an interim measure all patients were able to use the ward phone located within the multi-disciplinary team meeting room to provide patients with privacy. Patients were able to access their own mobile phones on section 17 leave and this was individually risk assessed.

Patients were not able to have personal access to the internet on the ward but were individually risk assessed to access computers based off the ward within the Humber Centre. The ward manager told us that patients had access to the internet off the ward five days per week and they were looking at patients' access to the internet and how this could take place on the ward.

Patients on the ward had access to a secure courtyard which was accessed by both the assessment and treatment side of the ward. The door on the treatment side of the ward was unlocked to allow patients free access into the area without the need to ask staff to access this area. Patients on the admission side of the ward required staff to unlock the door and be present in the area when they wished to access the garden area. Several patients on the assessment side of the ward described having to 'beg' staff to have access to this area. The ward manager had already been made aware of this issue by patients and was looking at this and how this could be addressed. In terms of patients on the assessment side garden access was not individually risk assessed and therefore was a blanket restriction. Management were looking at this as there was also ongoing safeguarding issues between some of the patients on the assessment and treatment side of the ward.

The ward manager told us they had updated the ward safety and security profile and found that room and personal searches were not taking place on the ward as per policy. Therefore the system had been changed and the ward manager explained that they recognised this was not required for all patients, and that all patients had been risk assessed and care planned to look at whether they required such searches.

The ward manager told us there was an independent mental health advocacy (IMHA) service available for patients. The ward referred each patient automatically to an IMHA on admission to the ward if they lacked capacity to understand what this service may offer them. The patient was then able to decide if they wished to be supported by an IMHA. The IMHA attended patients meetings should the patient consent. Staff told us they felt patients had timely access to an IMHA. The IMHA service provided a weekly open session to provide the patients opportunity to meet

with them on the ward.

We found relevant information on display for patients about how to complain, how to contact the IMHA service and how to contact the CQC.

We found patients were able to access facilities to make their own hot and cold drinks. Patients on the treatment side of the ward had access to a kitchen where they were also able to make hot and cold snacks.

We found that patients did have a key to access their bedrooms. Patients told us they were able to go in their bedrooms if they wished. Patients had access to lockable storage in their rooms they had lockable storage in their bed and in a drawer.

We found the ward was working to address blanket restrictions and restrictive practices. Where restrictions were required staff were looking at individualised risk assessments/care plans around these.

We reviewed two detained patient's records to find out whether they had been informed of their legal positon and rights as required under the MHA section 132. We found that the patients had been given this information in accordance with the Code of Practice.

The ward manager told us that carer support was offered to carers of patients on the ward. There was a Humber Centre carers group held monthly. The ward manager told us that last month they held a barbeque for carers. There was also a reducing restrictive practices group and we were told by the ward manager that carers were invited to participate in this meeting.

Assessment, transport and admission to hospital:

We found detention documents were available for scrutiny and appeared in order in the two patient's records we reviewed.

The ward manager told us both qualified and unqualified staff received training in the Mental Health Act. One member of staff was out of date on the training and was booked onto the next available course. The ward manager told us that all staff completed Mental Capacity Act training; again one member of staff was out of date on the training but was booked on further training. The ward manager told us there had been an improvement in the training figures for the ward.

Admissions to the ward would usually be planned following nominated staff on the ward completing a gatekeeping assessment. This ensured patients met the criteria admission for the ward. The ward manager told us that admissions would normally take place on a week day. There had been an admission to the ward on the day of our visit. Patients were usually admitted to the ward as a step down from high secure services, transfers from prison settings and at times patients from low secure settings as a step up in security.

Additional considerations for specific patients:

Swale ward was a specialist medium secure personality disorder ward for assessment and treatment.

The ward manager told us that the criteria for patients' admission to the ward was that they were mentally stable in order to complete a personality disorder assessment and treatment programme.

The ward manager told us that they were keen for all staff on the ward to be trained in the knowledge and understanding framework in personality disorder. This national training had been stopped but we were told had been recently restarted and the ward manager explained it was their focus for all staff on the ward to have this training. The ward manager was completing a training plan to have all staff complete this training within the next twelve months. The ward manager told us there was also some in house training that had been designed and peer supervision taking place to support staff to receive formulation coaching to support them in meeting patients' needs on the ward.

Care, support and treatment in hospital:

Patients on the ward received a ward round four weekly which they were invited to attend to discuss their care and treatment with the different professionals involved in their care. These meetings were recorded within the patients' records. Some patients we met told us they felt the meetings should be held more frequently. Staff told us that patients could see their RC and that a multi-disciplinary team meeting would be held in-between these times if required.

We viewed the seclusion room and found this to be in line with the Code of Practice (2015). We reviewed one recent episode of seclusion from August 2017. There had been no other episodes of seclusion prior to this period since December 2016, staff confirmed this. We found the majority of the records within this episode of seclusion were in line with the Code of Practice (2015). However we found there were some late two hourly nursing reviews, on one occasion there was a gap of four hours when a nursing review should have taken place. The ward manager and modern matron told us in feedback that they had picked this issue up in the seclusion audit and had addressed it with the relevant members of nursing staff.

We found the RC had made a record of the patients' capacity to consent to treatment either at first or most recent administration of treatment for mental disorder on the two patient's records we reviewed.

Staff told us that patients remained registered with their general practitioner (GP). However, the doctors on the ward met the majority of the patients physical healthcare needs or referred to specialists where required. There were no concerns raised by staff or patients about access to GP services or about their physical health needs.

Patients had a physical health assessment on admission and this was then repeated

annually. This was documented on the records we reviewed.

The ward manager told us that all patients had an individualised activity planner. On the day of our visit some patients attended a patient's council meeting, there were some therapy groups taking place off the ward and patients were being supported by staff to access their section 17 leave. We observed patients playing pool, darts and model making in the activities room. There were two band four members of nursing staff that linked with activities; one of these staff members was on duty on the day of our visit. There were also two activities workers linked to Swale ward and a full time OT allocated to the ward. Patients also received input from a full time psychologist and psychology assistants.

Patients had a weekly community meeting which they chaired. The ward manager would alternate their attendance to the community meetings held on the assessment and treatment side of the ward to ensure they attended each on a two weekly basis to action any issues raised.

We viewed the care plans for two patients on the ward. We found care plans had a consideration of the patients' diverse needs and provided an overview of the patients care and treatment whilst on the ward. There was evidence of patient involvement on the two patients care plans we viewed. Care plans had been reviewed recently. On the two patient records we viewed both had a risk assessments in place which contained a risk management plan.

Leaving hospital:

Both patients' records we reviewed had some section 17 leave in place. We found leave was usually discussed and approved/declined within the ward round meeting. We found the leave authorisation was appropriately recorded and included specified conditions. We found record that the patient had been offered a copy of their section 17 leave authorisation form. Ministry of Justice approval letters for leave were kept in the section 17 leave file.

We observed patients on the day of our visit being supported to take their escorted section 17 leave.

The ward manager told us there had been no recent patients go absent without leave.

The ward manager told us that patients' discharges from the ward were usually to a variety of settings. Patients who had been transferred from prisons for assessment and treatment were usually transferred back to prison on completion of this. Other patients were usually stepped down to low secure settings. On occasions we were told patients may be stepped back up to high secure settings where this was required.

Professional responsibilities:

The ward manager told us that qualified nurses received a checklist to ensure the

correct receipt of detention documentation. The MHA administror office checked and scrutinised these documents.

Tribunals and hospital manager's hearings took place when required.

The ward manager told us that lessons learnt were shared across the trust. They told us that debriefs took place after any incidents on the ward with psychology input. Support was also offered within supervision.

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**	**CoP Ref:** Chapter 8

We found:

Patients on the ward had access to a secure courtyard which was accessed by both the assessment and treatment side of the ward. The door on the treatment side of the ward was unlocked to allow patients free access into the area without the need to ask staff to access this area. Patients on the admission side of the ward required staff to unlock the door and be present in the area when they wished to access the garden area. Several patients on the assessment side of the ward described having to 'beg' staff to have access to this area. The ward manager had already been made aware of this issue by patients and was looking at this and how this could be managed. In terms of patients on the assessment side garden access was not individually risk assessed and therefore was a blanket restriction and management were looking at this as there was also ongoing safeguarding issues between some patients on the assessment and treatment side of the ward.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 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 patient's human rights."

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 26

We found:

We reviewed one recent episode of seclusion from August 2017. We found the majority of the records within this episode of seclusion were in line with the Code of Practice (2015) however we found there were some late two hourly nursing reviews, on one occasion there was a gap of four hours when a nursing review should have taken place. The ward manager and modern matron told us in feedback that they had picked this issue up in the seclusion audit and had addressed it with the relevant members of nursing staff.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) paragraph 26.134:

> "Nursing reviews of the secluded patient should take place at least every two hours following the commencement of seclusion. These should be undertaken by two individuals who are registered nurses, and at least one of whom should not have been involved directly in the decision to seclude."

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	B
Issue:	
Patient B met with us and told us they would like CCTV installing within the patient kitchen area on the treatment side of the ward to ensure patient safety. They told us that certain patients go into the kitchen and turn the lights off and that this then impacts on other patients making them feel unsafe in the kitchen area as it is dark when they enter. The patient suggested that if CCTV was not possible to explore whether the light could be fixed so that it remained permanently on. Please meet with the patient to discuss and update us of the outcome.	

Patient reference	D
Issue:	
Patient D met with us and told us that they were not receiving treatment for trauma or PTSD and told us they had been asking for this treatment and that it had not been provided. They said they had been assessed for over two years but not received any treatment. Please meet with the patient to discuss and update us of the outcome.	

Patient reference	E
Issue:	
Patient E met with us and told us that they had recently been care planned to have room searches and told us that they had been told they were going to receive 'cavity' searches (having mouth checked) following medication being administered. Patient E told us they felt very unhappy about this. Staff on the day of our visit told us there had been concerns about this patient selling patients tramadol on the ward and therefore they had been care planned to receive room searches. Staff told us they were not doing cavity searches but that two staff were present for the administration of this patients medication due to concerns. Please meet with this patient to discuss and update us of the outcome.	

Patient reference	F
Issue:	
Patient F met with us and wanted to raise the following issues; • Told us they were still waiting for their family photos to be returned to them to have in their bedroom. • Suggested the Humber Centre offer more groups jointly with other wards within the Humber Centre to provide patients with the opportunity to mix with patients off other wards, and felt this would also be beneficial as more activities could be offered as patients could be grouped together rather than run groups as individual wards. • Would like a pat dog/contact with animals. • Told us they have had no internet access for over two months and would like access. Please meet with this patient to discuss and update us of the outcome.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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