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:	Swale Unit
Ward type(s):	Acute Admission
Type of visit:	Unannounced
Visit date:	11 January 2016
Visit reference:	35465
Date of issue:	05 February 2016
Date Provider Action Statement to be returned to CQC:	25 February 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

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	☒	Purpose, respect, participation and least restriction	☐	Purpose, respect, participation and least restriction
☐	Patients admitted from the community (civil powers)	☒	Admission to the ward	☐	Discharge from hospital, CTO conditions and info about rights
☐	Patients subject to criminal proceedings	☐	Tribunals and hearings	☐	Consent to treatment
☐	Patients detained when already in hospital	☒	Leave of absence	☐	Review, recall to hospital and discharge
☐	People detained using police powers	☐	Transfers		
		☒	Control and security		
		☒	Consent to treatment		
		☒	General healthcare		

Findings and areas for your action statement

Overall findings

Introduction:

Swale Unit is a 15 bed male medium secure personality disorder unit located in the Humber Centre on the outskirts of Hull.

There were 14 patients on the unit on the day of the visit, all of whom were detained under the Mental Health Act 1983 (MHA).

Directly on entering the unit there was a large recreation area with a pool table and table tennis table. A meeting room was adjacent to the activity area.

There was a kitchen to facilitate cooking which was encouraged and forms part of the patients' activities.

There was a secure garden area which also provided a smoking area with a shelter provided for inclement weather.

All bedrooms were en suite with a toilet and a shower, all rooms had a lockable drawer and under bed storage.

Off the unit there was access to a visitors' room, a multi-faith room and a computer room.

The staff work 12 hour shifts with six staff on duty during the day and four staff on duty at night. Six staff were on duty at the time of the visit, two of whom were registered nurses and four were health care assistants. In addition, there was an occupational therapist, two activity co-ordinators and part-time psychology input. Medical care was provided by one consultant psychiatrist.

How we completed this review:

This was an unannounced visit and we would like to thank staff for their hospitality during the course of our visit.

We spoke with patients and staff informally. Five of the detained patients agreed to speak with us in private.

We looked around the facilities available on the unit and one patient showed us their bedroom.

We saw a range of information posted on noticeboards for patients. In addition, a range of symbols were posted throughout the ward to aid patient recognition.

We reviewed the MHA records and care plans for four patients.

What people told us:

We spoke with five patients. Most were very pleased or satisfied with the care they had received on the unit.

We were told by one patient, “staff treat me with respect.”

Another patient said, “the staff have really helped me with my care and treatment.”

One other patient said, “They see that you get the support you need. They’ve saved my life.” He was very positive about his experience on the unit after transferring from a prison setting.

In contrast one patient said, “I hate being here.” There were some staff whom he felt had not treated him well.

The patients all had copies of their own care plans and were allocated a named and associate nurse to work with them.

We spoke with the unit manager, who had recently transferred from another area to take the lead on Swale Unit. She told us that patients come to the ward from the prisons and the court system.

She had already introduced a more structured activities programme. She told us that in order for patients to benefit from the care and treatment provided on the unit, they have got to want to change. Each patient was assessed and involved in their own assessment using the Star recovery programme. Patients were involved in a range of activities to develop practical, psychological and social skills.

Past actions identified:

The last inspection took place on 25 September 2014 and the following concerns were raised on that visit.

- There was inconsistency in the completion of risk assessments with them not being signed by staff or patients.

  These concerns were fully addressed in all of the files reviewed

- Current leave forms were not always completed to evidence patients and relevant others had received a copy. This does not reflect practice as all patients spoken with informed us they were offered a copy of their leave forms.

  These concerns had been partly addressed. We saw in two of the four files reviewed that forms were still not being completed to evidence patients and

relevant others had received a copy.

- The recording of capacity to consent to treatment was not evident in the records reviewed.

  These concerns were partly addressed. In two of the four files we reviewed there was evidence of an assessment of capacity to consent to treatment. In one other file reviewed there was no assessment of capacity to consent to treatment. In another the patient was not being treated with medication for a mental disorder.

Domain areas

Purpose, respect, participation and least restriction:

We saw evidence that staff were providing an explanation of rights under section 132 MHA including access to the independent mental health advocate (IMHA) and this was repeated on a regular basis.

We reviewed the patient files and were satisfied that staff were fully involving patients in the planning of their care. There were daily entries in the records for each patient. These noted the patient's daily activities and behaviour, mental state and any additional comments relevant to the patient's care and treatment.

We were told that staff worked very closely with patients to develop their care plans and each patient had their own records they could keep in their rooms. We saw a range of documentation which indicated how patients were involved in their care.

We were very impressed with the depth of knowledge the staff had about their patients and how they anticipated their emotional and psychological needs. We listened to staff discuss various aspects of patient care and how they reflected on the approaches being taken to provide effective care.

We saw that patients appeared to be comfortable talking to the staff. We observed staff taking time to reassure patients and to discuss their worries with them. We also noted that staff, when supporting patients, took note of their preferences.

Admission to the ward:

We were able to inspect the MHA documentation for four patients who were detained under sections 47/49 and 37/41 of the MHA.

The detention documentation which we reviewed all appeared to be in order.

Tribunals and hearings:

This domain area was not reviewed on this visit.

Leave of absence:

The responsible clinician (RC) authorised section 17 leave and outlined clearly leave conditions.

We saw documentation indicating that staff risk assessed the patient before leave was taken and we were shown records of the outcomes of leave.

We saw two leave authorisations, which had not been 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.

Transfers:

This domain area was not reviewed on this visit.

Control and security:

We noted that the doors were controlled by keypads. Security regulations were tightly controlled to ensure that prohibited items were not brought onto the unit by patients or visitors.

We were able to inspect the seclusion room, which was not in use. The room and facilities appeared to comply with current code of practice guidance.

Consent to treatment:

We reviewed compliance with section 58 MHA requirements. The patients we spoke with about their treatment told us that they had been told about the medication being prescribed for them. We could not find evidence of this in the written records, which were kept in a paper file. The written records we saw were not easy to read and we may have missed references to the discussions held with patients about their medication.

Certificates authorising treatment were in place in accordance with legislative requirements

In the four records we reviewed, we saw records of assessments of capacity to consent to treatment for two patients. One further patient did not appear to have had an assessment of capacity to consent to treatment. In the case of the fourth patient's record we reviewed, the patient was not being treated with medication for a mental disorder.

We had concerns how consistently assessments of capacity to consent to treatment were being undertaken and could not find references to assessing capacity to consent to treatment in the care plans.

General healthcare:

The general healthcare needs of patients were reviewed by visiting general practitioners who attended the unit twice a week.

We were also introduced to the general nurse appointed to work across the Humber Centre to monitor and assess patients' physical health needs.

Other areas:

The trust may also like to review the following issues.

We had the opportunity to tour the unit and observed that there were a great number of notices/orders posted at the entrance to the unit and at various points throughout the ward.

There were 11 notices on and around the unit entrance. Most of which appeared to be information for staff rather than patient or visitor information. Those relating to security and prohibited items were already posted at the main entrance to the Humber Centre and compliance with them monitored by the staff on reception before access could be gained to the unit.

The notices posted in the unit related to a range of issues, for example, times when shaving equipment was available to patients, times when the bank was open, personal property in bedrooms, family visiting times and using the laundry.

We were concerned that some of the notices intended as information for patients were written in officious language and provided no explanation for the rules and regulations laid out in them. We even doubted the need for some of the notices. For example, 'Contraband Store No Patient Access' on a locked door. We appreciate that the rules and restrictions that were explained to us were needed on a medium secure unit, but we were concerned that the messages contained could be conveyed in more patient friendly language.

We discussed these notices with the unit manager and care group manager and agreed that this was an aspect of the unit that needed review. We were pleased that on leaving the unit the care group manager removed a number of these notices because they appeared to serve no useful purpose where they were posted.

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 Purpose, Respect, Participation, Least Restriction	**MHA section: 58** **CoP Ref: Chapter 13**

We found:

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

Your action statement should address:

How the trust will ensure that assessments of capacity are undertaken in accordance with 13.21 of the 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 Leave of absence	**MHA section: 17** **CoP Ref: Chapter 27**

We found:

Two leave authorisations, which had not been 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.

Your action statement should address:

How the trust will ensure in accordance with 27.22 of the CoP that copies of the authorisation should be given to the patient: "…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…."

Domain 2 Purpose, Respect, Participation, Least Restriction	CoP Ref: Chapter 1

We found:

That some of the notices intended as information for patients were written in officious language and provided no explanation for the rules and regulations laid out in them. We even doubted the need for some of the notices. For example, 'Please do not handle each other's laundry without prior agreement' and 'Contraband Store No Patient Access' on a locked door. We appreciate that the rules and restrictions that were explained to us were needed on a medium secure unit, but we were concerned that the messages contained could be conveyed in more patient friendly language.

Your action statement should address:

How the trust will ensure that the least restrictive option and maximising independence in accordance with 1.6 of the COP which states:

> …There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.

During our visit, the following specific issues were raised by patients regarding their care, treatment and human rights.

Individual issues raised by patients that are not reported above:

Patient reference:	A

Issue:

This patient did not feel he had had a clear explanation why he could not use a hard drive connected to his Xbox to transfer music from CDs to his hard drive.

Patient reference:	F

Issue:

This patient described his concerns that two members of staff were in his words "winding him up". He described events to us were he felt this had occurred. We asked him whether he had taken any action to complain. He told us that he had spoken to the unit manager about these issues. We discussed this with the unit manager and care group manager. We also discussed the names of the staff concerned and the incidents he had raised with us
We would appreciate action being taken to address this matter through the appropriate trust procedures.

Information for the reader

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Audience	Providers
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