Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Willerby Hill
Ward(s) visited:	Ouse
Ward types(s):	Secure Ward – Medium
Type of visit:	Unannounced
Visit date:	10 April 2017
Visit reference:	37494
Date of issue:	20 April 2017
Date Provider Action Statement to be returned to CQC:	11 May 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Ouse ward is a rehabilitation ward for 14 men in conditions of medium security. It forms part of the Humber Centre secure unit. On the day of the visit there were 14 patients allocated to the ward, all of whom were detained under the Mental Health Act (1983) (MHA).

The ward is designed around a central area with two bedroom corridors. None of the bedrooms had en suite facilities. Patients had access to an internal courtyard at all times. Access to drinks was available from a flask of hot water in a communal area.

There were two registered nurses and three health care assistants on duty, with a ward manager who manages two wards within the Humber Centre. Two consultant psychiatrists acted as responsible clinicians (RC) for this ward, one of whom was a locum. On the day of our visit, interviews were being held for a permanent consultant psychiatrist. Two patients from the ward were involved in the interview process.

The ward manager told us that the ward was in the process of becoming more 'streamline' with Derwent ward, which was the admission assessment ward where patients usually transferred from to Ouse ward. The ward manager told us that the plan was for the RCs to remain as the patient's RC from Derwent ward through to Ouse ward to provide consistency. They explained the wards would remain the same in terms of location and function, but felt this would offer a more streamlined service and facilitate a smoother transition for patients.

The deputy charge nurse told us that usual baseline staffing for the ward was five staff. This included two qualified nurses and the deputy charge nurse and ward manager would be additional to this. However, on the day of our visit the deputy charge nurse was the second registered nurse on the ward.

Staff worked a mixture of shift patterns to include long days, early, late and night shifts. The deputy ward manager told us they used bank and agency staff over the past three months on the ward. We were told that agency staff nurses had been taken on temporary short term contracts.

How we completed this review:

This was a scheduled unannounced visit to the ward by a Mental Health Act Reviewer. On arrival at the ward we met with the ward manager and deputy charge nurse. We interviewed the deputy ward manager. We had a tour of the ward and one patient showed us their bedroom. We met with three patients in private and other patients informally throughout the day of the visit.

Patient engagement forms were offered to patients and one form was returned completed.

We reviewed three sets of patients' records.

We provided verbal feedback to the ward manager and deputy charge nurse at the end of our visit.

What people told us:

We were able to meet with three patients in private during our visit. All other patients declined.

Staffing was the main theme highlighted by the patients we spoke to. Patients spoke about a "lack of staffing". When we asked what they felt the impact of this was, one patient raised concerns about patient safety because of lack of staffing. They explained that one patient attacks patients and felt there were not enough staff present to observe and prevent this happening. Another patient spoke of leave being shortened or postponed. However, we were informed that leave had not been cancelled due to staffing. A further patient told us "staffing very poor, not been on leave in months in the community".

Patients told us that they do not have keys to their bedrooms but that they are aware this is being looked at. They told us they would like keys to their rooms.

Generally patients spoke positively about staff who worked on the ward; "most staff are alright, get odd one who is on a power trip", "staff are alright but jobs don't get done properly" and "staff are ok in small doses".

Patients told us they felt activities were available. Patients told us they could access fresh air in the secure courtyard at any time and told us this was a positive thing.

Staff spoke about the difficulty of navigating their electronic recording system and how finding information on the system was a challenge.

Past actions identified:

The previous MHA monitoring visit was on 29 June 2015. The following issues was identified:

- That access to some bathrooms and toilets had been removed because they were awaiting upgrades. Some contained fitments that presented a ligature risk; others had inadequate ventilation and had pools of water on the floor that was unable to drain away. The patients' kitchen was closed for safety reasons after a cupboard fell off the wall. We were told that the kitchen would be upgraded, but that there was no time scale. Some areas of the ward, particularly the corridor doors, were showing signs of wear.

We found and staff told us that one bathroom had been completely refurbished since our last visit. The bathroom where drainage was an issue had been addressed. The two toilets had been locked off and were out of use. Patients had alternative toilets available for use and in bathrooms. The ward manager told us that the toilets had not yet been replaced as they were due in the next stream of works. The trust were considering adding en suite toilets to the patient's bedrooms. This stream of works was due to commence. The kitchen had been upgraded since our last visit. Patients required supervision in this area. The ward had recently been redecorated throughout and re-decoration works were still underway.

- That there were inconsistent assessments of capacity and consent to treatment in respect of the patients whose records we reviewed. That the forms for recording and monitoring capacity and consent to treatment that you provided for us with your last provider action statement were not in use.

  On the three records reviewed we found no issues.

- That one patient's T3 authorisation was in a different name to the patient's medicine card. The patient's latest renewal of detention was in a different name to the patient's original detention order. We were told that the patient had changed their name by Deed Poll. There was no record of this in either the medicine card or with the detention documents. The ward manager obtained a copy of the Deed from the patient during the visit and was going to insert it into the clinical record. The T3 was three years old and issued when there was a previous RC. It is good practice for SOAD's to review treatment plans regularly.

  On the three records reviewed we found no issues.

- That there were no facilities for patients to securely store items in their room. This is an outstanding action from our last visit following which you told us that "All patients will either have a lockable bedroom or a lockable cabinet within it." You told us would be completed by 31 March 2013.

  All patients had a lockable safe in their bedrooms. This issue had been resolved.

- That not all of the required documents relating to a patients current period of detention were available on the ward, although these were available from the trust MHA office on request. It is important that staff have access to a patient's record of detention and any associated documents in order to assure themselves that any treatment that they are giving in lawful.

  The system had changed so that all required documents relating to a patient's current period of detention were available on the electronic recording system. However, staff struggled to navigate this system to find the information and raised this as an area of concern. We made contact with the MHA legislation team who navigated us to the information but found the system challenging to navigate. This issue will be highlighted further in this report.

Domain areas

Protecting patients' rights and autonomy:

We found there were weekly community meetings held on the ward which patients attended. Staff told us that they felt the ward really encouraged patient involvement and told us that two patients were involved in recruiting a new RC on the day of our visit. We were told there had recently been set up a new patients council at the Humber Centre to support patient involvement.

Patients and staff told us that the secure courtyard was open and accessible for patients to be able to go outside and get fresh air. On the day of our visit we observed patients accessing the outdoor space throughout the day.

Patients did not highlight any concerns in terms of their privacy being respected. Patients who spoke to us did tell us they would like a key to their bedroom. Staff told us this was being looked at. The ward manager told us that they have now got keys to each of the patient's rooms and was in discussions about patients having keys to their bedrooms. We found this was a blanket restriction and the impact of this restriction was not considered individually.

The ward had a payphone; this was located in quite a busy area where other patients congregate outside the nurse's station. Staff told us patients could access a phone in a side room to contact advocacy and their solicitor. Patients were not able to have mobile phones on the ward.

The ward was attending meetings about restrictive practices and blanket restrictions and a recent change had been made to allow patients to access their mobile phones when on unescorted leave. One patient highlighted to us that they could not understand why they could not access a mobile phone on escorted leave but could access their smart phone on unescorted leave.

Patients were unable to have personal access to the internet on the ward. Patients were able with staff support to access the internet on computers in a designated area within the Humber Centre.

We found no information on display about the independent mental health advocacy (IMHA) service available for patients. The deputy charge nurse told us that the IMHA service visited the ward twice a week and attended ward rounds and other meetings in addition to this. Patients and staff raised no concerns regarding access to the IMHA service.

We found no information on display about how to complain and how to contact the Care Quality Commission (CQC). We were told this had been temporarily taken down whilst decorating work was being completed.

On our previous visit we raised a concern about patients not having access to

lockable storage in their rooms. We found on this visit that all patient bedrooms had a lockable safe available for patients to use.

We had concerns regarding the documenting and reading of patients' section 132 rights. We reviewed three patients' records. The electronic system was challenging to navigate to obtain the information. For one patient we were unable to find any record of their section 132 rights been read since 12 November 2015. We found one patient was last read their rights on 16 June 2016 but their section had been changed to a section 37/41 of the MHA on 20 February 2017. We found no record of them being informed of this. This was also checked and confirmed by the MHA legislation department.

Assessment, transport and admission to hospital:

We found detention documents were available for scrutiny for the three records reviewed. Approved mental health professional (AMHP) reports were present where required.

We found admissions to the ward were usually a transfer from Derwent ward within the Humber Centre which was the admission and assessment ward.Ouse was a treatment and rehabilitation ward.

Additional considerations for specific patients:

This area was not considered on the day of our visit.

Care, support and treatment in hospital:

Staff told us patients were registered with the local general practitioner (GP) service The GP visited the health hub within the Humber Centre weekly. The deputy charge nurse told us that there was also a general qualified nurse, a health care assistant and a manager for the service based within the health hub.

The deputy charge nurse told us that annual physical health checks were completed at the health hub and the ward manager confirmed this. However, we were unable to see evidence of this in the patient's records

Patients had activities on offer to them. On the day of our visit there was a gardening group in the morning and a walking group in the afternoon, which two patients attended. These activities were offered by occupational therapy assistants. Patients we spoke to did not raise any concerns about things to do on the ward and told us they mainly enjoyed playing pool, watching television and spending time in their rooms.

The deputy charge nurse told us there was one band seven occupational therapist and then eight occupational therapy assistants who worked across the Humber centre. The ward was allocated two occupational therapy assistants who worked Monday to Friday. We were told there were plans over the next few months for them

to start working over seven days and provide activites later into the day.

Patients had a multi-disciplinary team meeting monthly which they were invited to attend. We saw records of these happening on the notes for the three patients records we reviewed.

We found on the records we reviewed that 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. We were unable to find a record of patients being informed of the outcome of the second opinion appointed doctors' (SOAD) visits on the records reviewed.

We were concerned to find on the electronic records we reviewed there were no documented care plans. Staff told us these had been completed but were unable to locate these. We were not able to find entry in the notes of care plans reviews or named nurse discussions with the patients on the records we reviewed. We were not able to find records of patient or carer engagement in the care planning process. We were not able to find discharge care plans. We were further concerned to hear from staff that care plans on the electronic system were not easily accessible to them or to agency staff who had been covering shifts on the ward over the last few months.

We found risk assessments on the records we reviewed, and some had been updated recently. It was unclear what risk management plan was in use and again how this would be accessible to staff working on the ward as agency staff.

Staff told us no patients had been secluded on the ward since our last Mental Health Act visit in June 2015. We were told that some seclusion rooms within the Humber Centre had since been decommissioned. However, staff told us there were seclusion rooms available if these were needed. We did not review any seclusion records as none had taken place on the ward.

Leaving hospital:

We reviewed the section 17 leave forms for three patients whose records we reviewed. We found old section 17 leave authorisations which were not crossed through or cancelled which could have caused confusion to staff.

We found there were forms available to complete which were pre and post leave risk assessments but found these were not uploaded onto the electronic system and we could not find recent ones completed for the patients leave records we viewed.

For one patient we were not clear if they had been offered a copy of their leave authorisation as this section had been left blank. For one patient we were unable to see a copy of the approval from the Ministry of Justice for section 17 leave within the hospital grounds. The patient had recently received a hospital order with restricitons.

One patient raised concerns about not being able to go on leave which we have documented as an individual issue. However, we viewed the patient's record and found it confusing. The patient had escorted leave authorised by the RC, but within

the multi-disciplinary team (MDT) notes it was stated that the patient had no leave at present due to concerns about the patient's physical heath, breathlessness and lack of mobility. There appeared to be conflicting entries as other professionals had assessed the patient as being able to have access to leave as long as the patient had a wheelchair available and could access the adapted vehicle the Humber Centre had available. We were concerned, as we were unable to find a recent record of the patient having any recent leave.

Staff told us that discharges from the ward were to a variety of places. Some patients were transferred to conditions of low security. We were told some patients were discharged into the community with supported packages of care i.e. supported accommodation.

Professional responsibilities:

There was evidence of tribunals and hospital manager's hearings taking place.

Staff told us learning from incidents was shared at trust level through emails to staff. We were told by the deputy charge nurse that there had been no serious untoward incidents on the ward within the last twelve months.

Other areas:

The ward had recently been redecorated throughout and on the day of our visit there were still some areas mainly patients bedrooms being redecorated so some rooms where being used as temporary storage for the day i.e. a shower room.

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 1 and 8

We found:

Patients who spoke to us did tell us they would like a key to their bedroom. The ward manager told us that they have now got keys to each of the patient's rooms and was in discussions about patients having keys to their bedrooms. We found this was a blanket restriction and the impact of this restriction was not considered individually.

Your action statement should address:

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

"1.6 Restrictions that apply to all patients in a particular setting (blanket and global restrictions) should be avoided. 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.

"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**	**CoP Ref:** Chapter 4 and 6

We found:

We found no information on display about the independent mental health advocacy (IMHA) service available for patients.

We found no information on display about how to complain and how to contact the Care Quality Commission (CQC). We were told this had been temporarily taken down whilst

decorating work was being completed.

Your action statement should address:

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

"4.56 Information about how to make a complaint to the service commissioner, CQC or Parliamentary and Health Ombudsman should also be readily available.

"6.15 Certain people have a duty to take whatever steps are practicable to ensure that patients understand that help is available to them from IMHA services and how they can obtain help, as set out in the following table. This must include giving the relevant information both orally and in writing."

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

We found:

We had concerns regarding the documenting and reading of patients' section 132 rights. We reviewed three patients' records. The electronic system was challenging to navigate to obtain the information. For one patient we were unable to find any record of their section 132 rights been read since 12 November 2015. We found one patient was last read their rights on 16 June 2016 but their section had been changed to a section 37/41 of the MHA on 20 February 2017. We found no record of them being informed of this on the records. This was also checked and confirmed by the MHA legislation department.

Your action statement should address:

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

"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).

"4.29 A fresh explanation of the patients' rights should be considered in particular where:… Any significant change in their treatment is being considered…"

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 1 and 24

We found:

The deputy charge nurse told us that the annual physical health checks were completed at the health hub and the ward manager confirmed this. However, we were unable to see in the patient's records evidence of this or what these checks may have found.

Your action statement should address:

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

"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.

"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 **Care, support and treatment in hospital**	**MHA:** Section 58 **CoP Ref:** Chapter 25

We found:

We found no record of patients being informed of the outcome of the Second Opinion Appointed Doctors (SOAD) visit on the records reviewed.

Your action statement should address:

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

"25.66 It is the personal responsibility of the clinician in charge of the treatment to communicate the results of the SOAD visit to the patient. This need not wait until any separate statement of reasons has been received from the SOAD. But when a separate statement is received from the SOAD, the patient should be given the opportunity to see it as soon as possible, unless the clinician in charge of the treatment (or the SOAD) thinks that it would be likely to cause serious harm to the physical or mental health of the patient or any other person."

Domain 2 **Care, support and treatment in hospital**	**CoP Ref:** Chapter 1, 24 and 34

We found:

We were concerned to find on the electronic records that we reviewed that there were no documented care plans. Staff told us these had been completed but were unable to locate these. We were not able to find an entry in the notes of care plan reviews or named nurse discussions with the patients on the records we reviewed. We were not able to find records of patient or carer engagement in the care planning process. We were not able to find discharge care plans. We were further concerned to hear from staff that care plans on the electronic system were not easily accessible to them or to agency staff who had been covering shifts on the ward over the last few months.

We found risk assessments on the records we reviewed, some had been updated recently. It was unclear what risk management plan was in use and again how this would be accessible to staff working on the ward as agency staff.

Your action statement should address:

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

"1.7 Patients should be given the opportunity to be involved in planning, developing and reviewing their own care and treatment to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. Wherever possible, care plans should be produced in consultation with the patient.

"24.49 Wherever possible, the whole treatment plan should be discussed with the patient. Patients should be encouraged and assisted to make use of advocacy support available to them, if they want it. This includes, but need not be restricted to, independent mental health advocacy services under the Act. Where patients cannot (or do not wish to) participate in discussion about their treatment plan, any views they have expressed previously should be taken into consideration.

"34.10 Most importantly, the care plan should be prepared in close partnership with the patient from the outset, particularly where it is necessary to manage the process of discharge from hospital and reintegration into the community."

Domain 2 **Leaving Hospital**	**MHA:** Section 17 **CoP Ref:** Chapter 27

We found:

We reviewed the section 17 leave forms for three patients whose records we reviewed. We found old section 17 leave authorisations which were not crossed through or cancelled which could have caused confusion to staff.

We found there were forms available to complete which were pre and post leave risk assessments but found these were not uploaded onto the electronic system and we could not find recent ones completed for the patients leave records we viewed. For one patient we were not clear if they had been offered a copy of their leave authorisation as this section had been left blank. For one patient we were unable to see a copy of the approval from the Ministry of Justice for section 17 leave within the hospital grounds. The patient had recently received a hospital order with restricitons.

One patient raised concerns about not being able to go on leave which we have documented as an individual issue. However, we viewed the patient's record and found it confusing. The patient had escorted leave authorised by the RC, but within the multi-disciplinary team (MDT) notes it was stated that the patient had no leave at present due to concerns about the patient's physical heath, breathlessness and lack of mobility. There appeared to be conflicting entries as other professionals had assessed the patient as being able to have access to leave as long as the patient had a wheelchair available and could access the adapted vehicle the Humber Centre had available. We were concerned, as we were unable to find a recent record of the patient having any leave.

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)).

"27.23 The outcome of leave – whether or not it went well, particular problems encountered, concerns raised or benefits achieved – should be recorded in patients' notes to inform future decision making. Patients should be encouraged to contribute by giving their own views on their leave; some hospitals provide leave records specifically for this purpose.

"27.40 Where the courts or the Secretary of State have decided that restricted patients are to be detained in a particular unit of a hospital, those patients will require the Secretary of State's permission to take leave of absence to go to any other part of that hospital as well as outside the hospital."

During our visit, two 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	C
Issue:	
Raised concern about his section 17 leave. He told us that he had not been on leave for weeks and believes it is to do with moving on why he hasn't got any leave. On viewing the patients notes we found conflicting information. In an MDT on 28 March 2017 it stated the patient had no leave at present due to concerns about the patients physical health, breathlessness and lack of mobilitity. However, the patient had a section 17 leave authorisation for escorted leave within the grounds and community. However, there was no record of the patient having any recent leave. We referred to this also within the main body of the report. Please update us of the outcome.	

Patient reference	B
Issue:	
Told us that he was meant to been moved to conditions of low security. He told us he felt he has been in medium security to long saying his transfer has been going on for ten months and wants to know what is happening. Please update us of the outcome.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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