Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated Individual:	Angie Mason
Region:	North
Location name:	Miranda House
Location address:	Gladstone Street, Anlaby Road, Hull, HU3 2RT
Ward(s) visited:	PICU
Ward type(s):	Psychiatric Intensive Care Unit (PICU)
Type of visit:	Unannounced
Visit date:	10 August 2015
Visit reference:	34643
Date of issue:	17 August 2015
Date Provider Action Statement to be returned to CQC:	07 September 2015

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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

The Psychiatric Intensive Care Unit (PICU) at Miranda House in Hull is a 14 bedded mixed-gender ward. There are 10 male beds and four female beds. On the day of our visit there were 10 male patients on the ward all of whom were detained under the Mental Health Act (MHA).

The ward was locked and we saw several notices were posted giving clear information about access to the ward for visitors.

The ward has a range of activity areas including and activity kitchen on the floor upstairs, where patients can make meals under supervision. There is an art and craft room and a separate gym with a variety of exercise machines. There is a multi-functional room used for team meetings, interviews and patient telephone calls.

There are separate male and female areas, Within these gender-specific areas there are separate male and female television lounges and dining rooms. There are 11 en-suite bedrooms and three bedrooms.

The ward has a large courtyard to which patients have supervised access and is used as a smoking area.

There is a separate garden area, which patients have access to under supervision. The garden had a mix of flower beds and vegetable plots.

There is a low stimulus room that patients can use and a separate seclusion suite.

There is a patients meeting every week in which patients and staff discuss a range of issues in relation to care and treatment on the ward.

During the day there were five staff on duty with the ward manager or deputy charge nurses supernumerary. We noted that there was one qualified nurse and four health care assistants on a 12 hour shift during our visit. We were told that usually there are four staff on duty at night. The duty charge nurse was visiting another ward to assess a patient for admission when we arrived. We were told that there was currently no occupational therapy input to the ward because of maternity leave. The patients' medical care is managed by a consultant psychiatrist and two speciality doctors.

How we completed this review:

This was an unannounced visit.

We spoke with a few patients and staff informally. Two of the detained patients agreed to meet with us in private during the course of our visit.

We toured the facilities available on the ward and saw a range of information posted on noticeboards for patients.

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

We observed patients and staff interactions and communication throughout the visit and observed staff working calmly and with good humour with the patients.

What people told us:

One patient said, “The staff are friendly and the meals are nice.”

He talked at length about wanting to get home soon because his partner was expecting a baby. He appeared to have insight into how unwell he had been and how he was progressing now. He told us that staff wanted to move him to another ward but were finding it difficult to get a bed for him.

Another patient we spoke with said the staff were “fantastic.” He was waiting for a move back to another ward. He felt he was getting better and had calmed down.

We spoke with medical and nursing staff about the reasons why patients were waiting for beds in less restrictive environments and were told that the pressure on beds appeared to have got worse in the last twelve months. We were told that the ‘step-down’ facilities have high demand for their beds, which has the knock on effect for the PICU when patients are ready to be moved to a less restrictive area. Staff told us that they could identify five patients, who no longer needed care and treatment in PICU. This included one patient, who had been conditionally discharged by the First-tier Tribunal (Mental Health).

We note that in the previous visit in November 2013 delayed discharge from PICU was a feature of a service review taking place at that time. Whilst some of the factors causing delayed discharge may have changed, we were concerned that this was still occurring and patients were being detained longer than was necessary in a very restrictive environment. It seemed to us that the patients’ clinical needs were being outweighed by the practicalities of bed availability, which seemed inconsistent with the guiding principle of least restriction and maximising independence. One of the patients we spoke with, who was ready to move to another less restrictive ward, told us how he knew he had to speak carefully to other more severely ill patients for his own safety.

We were told by staff that there are a range of social and recreational activities which patients can take part in and organised on the ward. There was a well-used gym, as well as access to pool and table tennis. The art and craft room was also used by patients on a day to day basis.

We were shown the telephone room and discussed with staff whether the trust had a policy on the use of mobile phones, e-mail and internet access. The member of staff was not aware of a trust policy on the possession and use of mobile phones and mobile devices.

We discussed the use of the low stimulus bedroom with staff and were told that a care plan is drawn up for patients if this room is used for de-escalation or longer term segregation. We were satisfied that the staff give careful consideration to the use of this facility based on patient's needs. The staff we spoke with were unable to tell us whether the trust had any policies which guided the use of restrictive interventions.

Past actions identified:

At the last inspection completed on 19 November 2013, we identified concerns with:

- Ensuring that detained patients are given information about their rights under section 132 during their stay on the PICU as well as on admission.

  These concerns had been partially addressed. We saw some patient records indicating that an explanation of rights under section 132 had been given to patients, but there still appeared to be an inconsistent process for reminding patients of their rights after the initial explanation on admission.

  In one example we saw, there was a note by a staff member indicating that a repeat explanation should be attempted the day after an explanation had failed in mid-July, but after this entry there was no further entries in the record.

  The provider's action statement indicated that monthly audits and weekly checking would be undertaken to address this issue. We were disappointed to find this did not appear to have occurred.

Domain areas

Purpose, respect, participation and least restriction:

We were able to read the notes of the community meetings held every morning on the ward. The patients in the main appeared to have no significant recurring issues.

We saw notices posted on the ward about Independent Mental Health Advocacy (IMHA) as well as other information about access to the Patients Advice and Liaison Service (PALS) and how to complain. We were pleased to see that a wide range of information was available, but we found that the two noticeboards did not appear to be sufficient for the amount of information being posted, because some notices were obscuring other information. A further information board may be required.

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 saw evidence in the patient files of comprehensive, individualised care plans, which related to the patients mental and physical health, risk management, activities and legal status.

Admission to the ward:

We were able to inspect the MHA documentation for four patients. Two patients were detained under section 3 of the MHA, one patient was detained under section 2 and one under section 37.

All the patients appeared to be lawfully detained.

We found, in the case of one patient detained under section 3, that the Approved Mental Health Professional (AMHP) had made attempts but been unable to establish contact with the nearest relative when the application for detention was being made. We could not find any information in the patient's record indicating if a nearest relative had been identified.

Tribunals and hearings:

Patients were aware of their right to appeal and knew when their tribunals or hearings were due.

Leave of absence:
Section 17 leave forms were completed with time limits to the next review. We saw records showing that patients were routinely risk assessed prior to taking leave and a record of the outcome of the leave was recorded for each patient.
Transfers:
Transfer authorisation for patients admitted to the unit was present on all relevant patient files.
Control and security:
The ward was locked and entry and egress was via an ‘airlock’ room. The seclusion room appeared to comply with guidance set out in the CoP. We inspected the seclusion records of two patients and these appeared to very thoroughly recorded and in accordance with CoP guidance.
Consent to treatment:
We could only find one record that contained an assessment of capacity to consent to treatment. We also looked for evidence that patients were being given information about treatment being prescribed to them, where practicable, but could not find any records of this kind of discussion.
General healthcare:
We found evidence of physical healthcare assessments being routinely undertaken at the time of the patients’ admission.
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 Purpose, Respect, Participation, Least Restriction	**MHA section: 132** **CoP Ref: Chapter 4**

We found:

The patients' files showed that patients were given information regarding their rights on arrival on the PICU but did not provide evidence that this had been repeated. The monthly audits and weekly checking proposed in the trust's previous action statement to address this issue did not appear to have been carried out.

Your action statement should address:

How the trust will ensure that patients are kept informed of their rights in accordance with 4.28 of the MHA CoP which states:

> 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.

Domain 2 Consent to treatment	**MHA section: 58** **CoP Ref:** Chapter 13

We found:

Assessments of capacity to consent to treatment were not being completed for the majority of patients in accordance with CoP guidance.

Your action statement should address:

How the trust will ensure that clinicians act 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 Consent to treatment	**MHA section: 58** **CoP Ref:** Chapter 24

We found:

No evidence that patients were being given information about the treatment being prescribed to them, where practicable.

Your action statement should address:

How the trust will ensure that patients are given an explanation of their treatment, where practicable in accordance with 24.37 of the CoP which states:

> The information which should be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information should be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients.

Domain 2 Admission to the ward	MHA section: 26 CoP Ref: Chapter 5

We found:

One patient detained under section 3 did not appear to have had a nearest relative identified within the meaning of the Act.

Your action statement should address:

How the trust will ensure in collaboration with the local authority that a nearest relative is identified or appointed in accordance with 5.6 of the CoP which states:

> Where an approved mental health professional (AMHP) discovers, when assessing a patient for possible detention or guardianship under the Act (or at any other time), that the patient appears to have no nearest relative, the AMHP should advise the patient of their right to apply to the county court for the appointment of a person to act as their nearest relative. If the patient lacks capacity to decide to apply themselves, the AMHP should apply to the county court.

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

We found:

Patients discharges from PICU were being delayed because beds were not available for them in less restrictive environments.

Your action statement should address:

How the trust will ensure that the least restrictive option and maximising independence principle is applied to patients detained on PICU in accordance with 1.4 of the CoP which states:

If the Act is used, detention should be used for the shortest time necessary in the least restrictive hospital setting available, and be delivered as close as reasonably possible to a location that the patient identifies they would like to be close to (eg their home or close to a family member or carer). In cases where the patient lacks capacity to make a decision about the location they would like to be close to, a best interests decision on the location should be taken. This will promote recovery and enable the patient to maintain contact with family, friends, and their community.

Domain 2 Purpose, Respect, Participation, Least Restriction	MHA section: CoP Ref: Chapter 8

We found:

Staff were not aware of a trust policy on the possession and use of mobile phones and mobile devices.

Your action statement should address:

How the trust will ensure that a policy on the possession and use of mobile phones and mobile devices is available for staff and patients in accordance with 8.19 of the CoP which states:

> Hospital managers should have a policy for the possession and use of mobile phones and other mobile devices (such as laptops and tablets). These should be proportionate to risk and not seek to impose blanket restrictions on patients.

Domain 2 Purpose, Respect, Participation, Least Restriction	MHA section: CoP Ref: Chapter 26

We found:

The staff we spoke with were unable to tell us whether the trust had any policies which guided the use of restrictive interventions in regard to the low stimulus room.

Your action statement should address:

How the trust will ensure that procedures for the safe use of restrictive interventions such as the low stimulus room are set out in accordance with guidance in Chapter 26 of the CoP.

During our visit, no patients raised specific issues regarding their care, treatment and human rights.

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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