Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Westlands
Ward(s) visited:	Westlands
Ward types(s):	Acute wards for adults of working age
Type of visit:	Unannounced
Visit date:	1 March 2017
Visit reference:	37403
Date of issue:	9 March 2017
Date Provider Action Statement to be returned to CQC:	29 March 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Westlands is an acute 18 bed ward for females of working age located in Hull.

On the day of our visit there was 16 patients allocated to the ward, 13 patients were detained under the Mental Health Act 1983 (MHA). Three patients were informal. Two patients were on overnight leave. No detained patients were placed on the ward from out of area on the day of our visit.

The unit was set out over two levels. Downstairs there were two separate lounge areas, a dining area where hot and cold drinks were accessible, a quiet room, a seclusion room, the nursing office, an interview room, two clinic rooms and some staff offices. There was also one patient bedroom which was not in use on the day of our visit as the windows were being replaced. The door to the garden area with smoke shelter was open. The larger garden was locked off on the day of our visit due to building work. On the first floor there were the remaining bedrooms, bathing and toilet facilities and a small lounge.

Baseline staffing for the unit was six staff on a morning shift, six staff on an afternoon and five staff on a night shift which included two qualified nurses on each shift. The unit manager told us that staffing numbers was increased by one each shift towards the end of 2016 following a trust review which indicated the ward required an increase in staffing. Posts were being recruited to. The unit manager told us the unit was going to have three deputy nurses which had been increased from two.

On the day of our visit there were two qualified nurses on shift and four healthcare assistants. We observed the ward was struggling to cover the afternoon shift due to staff cancelling their shift. The unit did rely on bank and agency staff. We were told there are hopes this will reduce when staff have competed the recruitment process.

Patients had access to psychology and occupational therapy. Staff told us there was usually a social worker based on site but that they were undertaking their Approved Mental Health Professional (AMHP) training. There was a band four and band three activities workers who were full time and worked over seven days each covering alternate weekends.

The consultant psychiatrist started at Westlands a couple of weeks before our visit and had transferred from another inpatient unit within the trust. The consultant psychiatrist was the responsible clinician (RC) for all patients on the ward and was based on site. The unit manager told us there was no speciality doctor for Westlands and this position was being recruited to. We saw a visiting on call doctor on the ward during our visit.

How we completed this review:

This was a routine unannounced visit to the ward by a Mental Health Act Reviewer. On arrival at the ward we met with the unit manager. We had a tour of the unit.

We met with four patients as part of a focus group. All patients declined the opportunity to meet in private. Patient engagement forms were provided and eleven were returned completed. We reviewed three sets of patients' records and viewed seclusion records for all episodes of seclusion in 2017 up to the day of the visit. We met with staff informally and interviewed the unit manager.

We provided verbal feedback to the unit manager at the end of our visit.

What people told us:

Patients spoke about the unit and told us "the night is more relaxed here and there is more going on in the day which is good". Patients told us "I feel safe here".

Patients told us about staff that "I feel staff do the best they can, with leave sometimes they have to postpone it if short staffed but they always do it as soon as they can". One patient told us that there had been a change of doctors but that they felt contact with the doctor was ok before and they were waiting to see what the new doctor was like. Patient engagement forms told us told us that patients thought staff were "ok", "good", "kind and caring" one patient put that they were "unhappy" with staff.

When patients we spoke to were asked about care plans we were told "what's a care plan" and "not sure about my care plans". However, they were aware they had a 'recovery star'.

Patients told us they were able to access fresh air when they wanted in the garden area.

Patient engagement forms generally raised no concerns about food scoring that they were "very happy" with the food. Themes the patients engagement forms picked up were that five patients scored that they were very unhappy with discharge planning. Three patients put they were unhappy with care planning. Most patients put they were happy with the activities and things to do on the ward but three patients scored they were very unhappy with things to do on the ward.

We spoke with staff informally throughout the day. The unit manager spoke of charitable bids she had put in for the ward to improve the environment but was awaiting decisions to be made by the trust as to whether they would support with some of the work.

Past actions identified:

The previous MHA monitoring visit was on 3 November 2015. The following issues was identified:

- There were concerns raised about a patient who was shouting and swearing outside of the unit in the garden and staff had not attended. A similar issue had happened later during the visit. There were concerns rose that staff were not always available to address patient need. We had difficulty finding staff to attend to a patient who was not well in the lounge. We did not find that staff encouraged patients to join in activities.

We did not find this to be an issue on the day of our visit. We observed positive interaction between staff and patients and observed staff attending to patients. Staff held activities for patients during the day and supported some patients into the community.

- There was no evidence that patients had been given a copy of their care plan. Some patients told us that they were not involved in their care and that treatment had not been explained to them. Two patients said they did not know where facilities such as the laundry room were. They also said they could not always identify staff because their name badges were not visible.

Issues around care planning and patient involvement in care planning remained and forms a further action point. No patients raised concerns about not been aware of where facilities were. We observed staff to have name badges visible.

- Patients did not have a key to their bedrooms. This was a blanket rule covering all patients rather than subject to a risk assessment. This was an issue raised on the previous visit as a restrictive practice. In the community meetings patient had said when the ward was busy there was no staff to let them into their bedrooms or laundry.

We were concerned that this issue remained and had been picked up on two previous visits. This forms a further action point.

- Some patients told us that they could not have section 17 leave due to staffing levels. We found some out of date section 17 leave forms had not been deleted, although they did display start and end dates. We found that section 17 leave forms were not signed by patients. There was no evidence copies of leave forms had been given to patients or others such as carers who were involved in some leave arrangements.

This issue was partially resolved. We did not find any out of date section 17 leave forms in the records reviewed. However, we did find that leave forms were not signed by patients and there was no record of patients or relevant others receiving copies of the leave form. Patients told us there are times when leave was postponed

due to ward activity and staffing but that leave happened as soon as possible to the time it was meant to take place.

- The unit used the Galatian Risk and Safety Tool (GRiST) to assess risk issues. We expressed a concern that one patient scored highly on the tool but had substantial section 17 leave. We highlighted that this needed immediate review. Patients told us they did not always feel safe on the unit. They could not access their rooms without staff, and bedrooms could be a safe place when the ward was unsettled. We had difficulty in locating staff at times during our visit, and we highlighted that the building was difficult for five staff to cover.

These concerns were partially met. The unit staffing numbers had increased by one member of staff per shift. Patients did not raise concerns with us on the day of the visit about feeling unsafe on the ward. We found the unit no longer use the GRiST tool and this has been replaced by a trust risk assessment until a new risk assessment tool was implemented across the trust. However we were concerned to find that for two patients out of the three records reviewed we were unable to find a risk assessment and the other patients risk assessment had not been reviewed since January 2017.

- We could not find on one patients file a record of the RCs discussion with the patient about medication and assessment of their capacity to consent. The patient's treatment required authorisation under section 58 procedures two days after our visit. Staff told us the RC had met with the patient and established that she had capacity to consent. There was no documented evidence that this had taken place.

This issue remained on the records we reviewed on the day of the visit.

Domain areas

Protecting patients' rights and autonomy:

The general unit areas such as lounges, dining room and access to the garden were unlocked and accessible to patients without the need of staff support. One garden was locked off on the day of our visit this was due to building maintenance as bedroom windows were being replaced to anti-ligature windows. Patients were able to smoke in the designated smoking area outside. Patients were able to access hot and cold drinks in the dining room.

We found weekly community meetings took place on the unit and these were documented. We reviewed the previous two meetings. The last meeting was on 28 February 2017. We found in the minutes that actions from the previous meeting were revisited.

The unit manager told us there was a regular monthly carer's support forum provided by 'Rethink' which had recently restarted. We were told at times Rethink carer support workers would visit carers directly to provide support. Other times Rethink would spend time in reception to introduce themselves to carers.

The ward was entered through locked doors. We found informal patients needed to ask staff to leave the ward. We observed no information on display for informal patients to tell them of their rights to leave the unit. Access to and from the unit for informal patients was an issue Humber NHS Foundation Trust highlighted in the last provider action statement as an area audits would be carried out and action taken to support informal patient's access and egress from the unit.

We found no patients had a key to their bedroom and were required to ask staff to open their room. This was a blanket restriction and not individually risk assessed for each patient. The issue had been highlighted on our previous two mental health act monitoring visits.

The provider action statement following our last visit told us that Humber NHS Foundation Trust would be undertaking an audit of the clinical environment to review restrictions that limit access to the bedrooms and access and egress from the unit for informal patients. A plan of potential solutions would then be generated for costings for the trust board to review and make a decision. The unit manager told us these actions had taken place and that it was with the trust make a final decision on.

We found patients had no lockable storage in their bedrooms for their personal possessions.

We found there was a lack of information on display for patients around the unit. We were unable to find information on display about how to complain and how to contact the Care Quality Commission (CQC). We did not see any information on display about the Independent Mental Health Advocacy (IMHA) service and how to contact them. However, patients we spoke to told us they were aware of the IMHA service.

Staff told us a patient had recently caused damage to all the display boards and display boards had been removed until suitable alternatives were found to replace these boards.

Patients had access to their own mobile phones on the ward. We found that patients had access to the internet once a week in a technology group.

Staff told us referrals were automatically made to the IMHA service where a patient lacked capacity by the mental health act legislation team. However, this was not clear in the records reviewed. Staff confirmed there was timely access to the IMHA service.

We found on the three records reviewed that patients required their section 132 rights reading. One patient had declined their section 132 rights to be read on 23 February 2017 but there was no record of them being revisited with the patient. For one patient we found no record of their rights being read on admission or revisited since. It was unclear from the records if a referral had been made to the IMHA service. In the third patient's records we reviewed we found that they had, had their rights read for the first two days of admission where it was recorded they did not understand and to revisit their rights on 19 January 2017 but there was no further record that this happened.

Patients we met with told us that they were not sure if they had been read their rights. One patient told us "if they did read rights I was unwell so wouldn't know". Several patient engagement forms indicated patients were unhappy with information given to them about their rights.

Assessment, transport and admission to hospital:

We found that not all detention documents were available for scrutiny for the three records reviewed. On one patient's records reviewed we were able to locate copies of their section renewal but not copies of the original detention documents. We viewed several volumes of their notes and were not able to locate these. On another patient's records reviewed we found copies of page one of the application by the AMHP for admission for treatment and the joint medical recommendation for admission for treatment but pages two and three were missing for both. AMHP reports were available on two patients records reviewed.

Staff told us admissions were sometimes direct from the community but mainly from Avondale which was the admission and assessment ward within Humber NHS Foundation Trust. Staff told us female patients who were recalled from their community treatment order or who were detained under section 3 of the MHA were usually admitted directly to Westlands. Admissions could take place at any time of the day or night.

Additional considerations for specific patients:

This area was not reviewed on the day of the visit.

Care, support and treatment in hospital:

Patients usually remained registered with their local general practitioner (GP). There was records in the files we reviewed that patients were having identified physical health needs met through attendance at relevant hospital appointments and referred to specialists where required. Staff told us that on admission patients have a physical health check.

On one patient's record we reviewed we found a physical health check as part of the admission paperwork left blank. In two further records we reviewed we were not able to find record of a physical health check taking place. The unit manager told us that a Health Improvement Profile was completed for each patient and the information went on a database. We were unable to find information about any physical health needs identified from this tool within patient records.

Patients appeared to have activities available daily. On the day of our visit there was a breakfast group that took place followed by a trip to the local market. We observed several patients return from the trip with staff and patients spoke positively about this. A yoga session was offered to patients in the afternoon and a psychological therapy group was attended by some patients. Patients told us about a recent cinema night they had at the weekend which they said they enjoyed.

The unit had a full time Occupational Therapist who was supported by two activities workers who worked alternate weekends to provide meaningful activities to patients over seven days. There was a two weekly programme of activities. We found in the community meeting minutes that activities were discussed to find out from patients any activities they would like to be introduced on the ward.

Patients care plans was an area of concern. The unit manager told us that the trust was in the process of reviewing care plans. All patients have a recovery star and additional specific care plans were introduced by the nursing staff for the patients.

We reviewed three patients records and found that recovery stars and short term care plans were rather prescriptive and directive towards the patient rather than written in collaboration with the patient and relevant others such as family. The area of the form identified for patients to sign and to indicate if patients had received a copy were left blank on the records reviewed. It was not clear when care plans were reviewed with patients. There was several care plans in the files and it was not clear which were no longer in use. We were aware the unit uses bank and agency staff and were concerned that they would be unable to access this information easily.

This was an area of concern on our last visit. The previous provider action statement indicated that an audit of case notes would take place on a weekly basis and feedback would be given to the key worker with an action plan if needed. We could not find record of this taking place.

Staff told us the unit had weekly zonal meetings to review patients with members of the multi-disciplinary team (MDT) but these were not recorded and weekly care recovery meetings which were documented. We found a lack of patient involvement

in the care recovery meetings. Patients were not invited to attend these meetings; feedback was obtained outside of the meeting from patients and sometimes not inputted onto the form.

We found that the trust no longer used the GRiST risk assessment. The trust used an interim risk assessment tool while they reviewed which tool to use. We were concerned that for two patient's records we reviewed we found no record of a risk assessment. Further for one patient where we could not find a risk assessment present they were on overnight leave home after refusing to return to the ward. For the other patient the risk assessment had last been updated in January 2017.

On the three records reviewed we found no clear record of the RC's record detailing their assessment of the patient's capacity to consent to treatment on admission.

We viewed the seclusion records for 2017 up to the date of the visit. It appeared that there had been four episodes of seclusion in that period. On the form which documented seclusions that had taken place in the seclusion file we found one seclusion was not documented on the form.

We found it challenging reviewing the seclusion records as not all the documents relating to each seclusion were kept in the seclusion file where the unit manager told us that all copies should be kept. We found paperwork for seclusions in patient's files but this was located in different parts of the file which made this difficult to view to ensure seclusions were in line with the Code of Practice (2015).

We found a lack of nursing reviews being documented across the seclusions where two hourly nursing reviews were missed or late. The unit manager confirmed that the unit was aware of this issue through audits completed. For example for the seclusion that took place on 24 January 2017 we found there was no two hourly nursing review until 7.30am when it was due at 6.20am, we found no nursing review took place at 8.20am. The seclusion that took place on 18 February 2017 a nursing review was due at 4.45pm but was not recorded as taking place.

Leaving hospital:

In the three records reviewed two patients had section 17 leave in place. One patient had had section 17 leave in place for medical treatment which was appropriately authorised by the RC.

We found no clear record of how leave was authorised on the basis of a risk assessment. We were able to see the leave authorisation form but on the date granted we were not able to find record of where this was discussed and risk assessed. We were concerned , as one patient who had gone on section 17 leave home and had refused to return had been approved two further overnight leaves but we were unable to find record of the risk assessment by the RC around this documented.

We found section 17 leave forms had not been signed by the patient. The area of the form to record a copy of the section 17 form was given to the patient or relevant

others such as family supporting the leave was left blank. This was an issue identified on our last visit.
Professional responsibilities:
There was evidence of tribunals and hospital manager's hearings taking place. The trust had a checklist to support that the correct receipt of detention documentation was followed and this was then scrutinised by the MHA legislation department. The unit manager told us that band six nurses attend a two weekly charge nurse meeting where learning from incidents was shared and there was an acute care forum held monthly where incident feedback was shared. The expectation was then the charge nurses would disseminate this information to staff on the wards.
Other areas:
No other areas to report.

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 4
We found:	
We found there was a lack of information on display for patients around the unit. We were unable to find information on display about how to complain and how to contact the Care Quality Commission (CQC). We did not see any information on display about the Independent Mental Health Advocacy (IMHA) service and how to contact them.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraph: 4.56 Information about how to make a complaint to the service commissioner, CQC or Parliamentary and Health Ombudsman should also be readily available.	

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

We found:

We found on the three records reviewed that patients required their section 132 rights reading. One patient had declined their section 132 rights to be read on 23 February 2017 but there was no record of them being revisited with the patient. One patient we found no record of their rights being read on admission or revisited since. It was unclear from the records if a referral had been made to the IMHA service. For the third patients records we reviewed we found that they had, had their rights read for the first two days of admission where it was recorded they did not understand and to revisit their rights on 19 January 2017 but there was no further record that this happened. On the patient engagement forms returned several indicated they were unhappy with the information on rights i.e. have your rights been explained to you.

Your action statement should address:

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

> 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)."

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 1 and 4

We found:

The ward was entered through locked doors. We found informal patients needed to ask staff to leave the ward. We observed no information on display for informal patients to tell them of their rights to leave the unit. Access to and from the unit for informal patients was an issue Humber NHS Foundation Trust highlighted in the last provider action statement as an area audits would be carried out and action taken to support informal patient's access and egress from the unit.

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."

4.51 "Informal patients must be allowed to leave if they wish, unless they are to be detained under the Act. Both the patient and, where appropriate, their carer and advocate should be made aware of this right with information being provided in a format and language the patient understands. Local policies and arrangements about movement around the hospital and its grounds must be clearly explained to the patients concerned. Failure to do so could lead to a patient mistakenly believing that they are not allowed to leave hospital, which could result in an unlawful deprivation of their liberty and a breach of their human rights."

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 8
We found:	
We found patients had no lockable storage in their bedrooms for their personal possessions.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraph: 8.24 "Hospitals should provide adequate storage in lockable facilities (with staff override) for the clothing and other personal possessions which patients may keep with them on the ward and for the secure central storage of anything of value or items which may pose a risk to the patient or to others, e.g. razors. Information about arrangements for storage should be easily accessible to patients on the ward. Hospitals should compile an inventory of what has been allowed to be kept on the ward and what has been stored and give a copy to the patient. The inventory should be updated when necessary. Patients should always be able to access their private property on request if it is safe to do so."	

Domain 2 **Protecting patients' rights and autonomy**	**CoP Ref:** Chapter 8

We found:

We found no patients had a key to their bedroom and were required to ask staff to open their room. This was a blanket restriction and not individually risk assessed for each patient. The issue had been highlighted on our previous two mental health act monitoring visits.

The provider action statement following our last visit told us that Humber NHS Foundation Trust would be undertaking an audit of the clinical environment to review restrictions that limit access to the bedrooms and access and egress from the unit for informal patients. A plan of potential solutions would then be generated for costings for the trust board to review and make a decision. The unit manager told us these actions had taken place and that it was with the trust make a final decision on.

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 a patient's human rights."

Domain 2 **Assessment, transport and admission to hospital**	**CoP Ref:** Chapter 14 and 17

We found:

We found that not all detention documents were available for scrutiny for the three records reviewed. On one patients records reviewed we were able to locate copies of their section renewal but not copies of the original detention documents. We viewed several volumes of their notes and were not able to locate these. On another patients records reviewed we found copies of page one of the application by the AMHP for admission for treatment and the joint medical recommendation for admission for treatment but pages two and three were missing for both.

Your action statement should address:

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

> 14.93 “The AMHP should provide an outline report for the hospital at the time the patients first admitted or detained, giving reasons for the application and any practical matters about the patient’s circumstances which the hospital should know. Where possible, the report should include the name and telephone number of the AMHP or care coordinator who can give further information. Local authorities should use a standard form on which AMHPs can make this outline report”
>
> 37.12 “It is the hospital managers’ responsibility to ensure that the authority for detaining patients is valid and that any relevant admission documents are in order. A copy of the report made by the approved mental health professional (AMHP) should also be obtained. Hospital managers should have a clear system in place for notifying local authorities when the patient is a child or young person. For guidance on the receipt, scrutiny and rectification of documents see chapter 35.”

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

We found:

On one patient's record we reviewed we found a physical health check as part of the admission paperwork left blank. In two further records we reviewed we were not able to find record of a physical health check taking place. The unit manager told us that a Health Improvement Profile was completed for each patient and the information went on a database. We were unable to find information about any physical health needs identified from this tool within patient records.

Your action statement should address:

How you will demonstrate adherence with the following Code of Practice (2015) 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	CoP Ref: Chapter 1 , 24 and 34

We found:

Patients care plans was an area of concern. The unit manager told us that the trust was in the process of reviewing care plans. All patients have a recovery star and additional specific care plans were introduced by the nursing staff for the patient.

We reviewed three patients records and found that recovery stars and short term care plans were rather prescriptive and directive towards the patient rather than written in collaboration with the patient and relevant others such as family. The areas which were identified for patients to sign and to indicate if patients had received a copy were left blank on the records reviewed. It was not clear when care plans were reviewed with patients. There was several care plans in the files and it was not clear which were no longer in use. We were aware the unit uses bank and agency staff and were concerned that they would be unable to access this information easily.

This was an area of concern on our last visit. The previous provider action statement indicated that an audit of case notes would take place on a weekly basis and fed back to the key worker with an action plan if needed. We could not find record of this taking place.

Staff told us the unit had weekly zonal meetings to review patients with members of the multi-disciplinary team (MDT) but these were not recorded and weekly care recovery meetings which were documented. We found a lack of patient involvement in the care recovery meetings. Patients were not invited to attend these meetings; feedback was obtained out of the meeting from patients and sometimes not inputted onto the form.

Your action statement should address:

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

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

We found:

We found that the trust no longer used the GRiST risk assessment and was using an interim risk assessment introduced by the trust until the risk assessment which would be implemented across the trust was agreed. We were concerned that for two patient’s records we reviewed we found no record of a risk assessment. For the other patient the risk assessment had last been updated in January 2017.

Your action statement should address:

What action you will take to ensure that risk assessments are completed, regularly reviewed and present on the patient files. This was an action identified on our previous MHA monitoring visit. We were concerned as one patient where we could not find a risk assessment present was on overnight leave home after refusing to return to the ward.

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

26.14 “When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. These assessments should inform the patient’s care programme approach (CPA) care plan and/or positive behaviour support plans (or equivalent) (see paragraphs 26.18 – 26.27).”

26.15 “Staff should ensure that patients who are assessed as being liable to present with behavioural disturbance have a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies (see paragraphs 34.2 – 34.5). In some services such a care or treatment plan is referred to as a positive behaviour support plan. These individualised care plans, should be available and kept up to date…”

Domain 2 Care, support and treatment in hospital	CoP Ref: Chapter 25
We found:	
On the records reviewed we found no clear record of the RC record of assessment of the patient's capacity to consent to treatment on admission.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraph: 25.17 "Where approved clinicians certify the treatment of a patient who consents, they should not rely on the certificate as the only record of their reasons for believing that the patient has consented to the treatment. A record of their discussion with the patient including any capacity assessment should be made in the patient's notes as normal."	

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

We found:

We viewed the seclusion records for 2017 up to the date of the visit. It appeared that there had been four episodes of seclusion in that period. On the form which documented seclusions that had taken place in the seclusion file we found one seclusion was not documented on the form. We found it challenging reviewing the seclusion records as not all the documents relating to each individual seclusion were kept in the seclusion file where we understood that all copies should be kept.

We found paperwork for seclusions in patient's files but this was located in different parts of the file which made this difficult to view to ensure seclusions were in line with the Code of Practice (2015).

We found a lack of nursing reviews being documented across the seclusions where two hourly nursing reviews were missed or late. The unit manager confirmed that the unit was aware of this issue through audits completed.

Your action statement should address:

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

> 26.131 "Continuing four-hourly medical reviews of secluded patients should be carried out until the first (internal) MDT has taken place including in the evenings, night time, on weekends and bank holidays. A provider's policy may allow different review arrangements to be applied when patients in seclusion are asleep."
>
> 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."

Domain 2 Leaving Hospital	MHA section: 17 CoP Ref: Chapter 27

We found:

We found no clear record of how leave was authorised on the basis of a risk assessment. We were able to see the leave authorisation form but on the date granted we were not able to find record of where this was discussed and risk assessed. We were concerned , as one patient who had gone on section 17 leave home and had refused to return had been approved two further overnight leaves but we were unable to find record of the risk assessment with the RC around this documented.

We found section 17 leave forms had not been signed by the patient where there was an area on the form for this to take place. The area of the form to record a copy of the section 17 form was given to the patient or relevant others such as family supporting the leave was left blank. This was an issue identified on our last visit.

Your action statement should address:

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

> 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)).”

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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