# Mental Health Act 1983 monitoring visit

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| **Provider:** | Humber NHS Foundation Trust |
| **Nominated Individual:** | Jules Williams |
| **Region:** | North |
| **Location name:** | Maister Lodge |
| **Location address:** | Hauxwell Grove, Hull, Humberside. HU8 0RB |
| **Ward(s) visited:** | Maister Lodge |
| **Ward type(s):** | Old age psychiatry |
| **Type of visit:** | Unannounced |
| **Visit date:** | 27 May 2015 |
| **Visit reference:** | 34141 |
| **Date of issue:** | 10 June 2015 |
| **Date Provider Action Statement to be returned to CQC:** | 30 June 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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 | |
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| ☐ | 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:**

Maister Lodge is a 16 bed ward for older people of both sexes with organic illnesses leading to memory problems. On the day of the visit there were 12 patients allocated to the ward, nine males and three females. 10 patients were detained under the Mental Health Act 1983 (MHA) and two were subject to deprivation of liberty safeguards (DoLS). One patient was being nursed at the local acute hospital following a deterioration in their physical health.

When we visited, the ward was staffed with two registered nurses, one of whom had been transferred from the functional older peoples ward, three bank health care support workers and an agency health care support worker. There was one regular health care support worker supporting the patient at the local acute hospital. We were told that clinical leadership for the ward was provided by the modern matron, the charge nurse on the functional ward and from within the community team because the charge nurse and the two deputy charge nurses were on long term sick leave. We were told that a health care support worker worked a twilight shift between 4pm and midnight. We were told that there were five or six staff on duty at night. We were told that the ward was making significant use of bank staff and some agency staff because of staff shortages. We were told that the ward had 6.8 registered nurse vacancies and had recently recruited to 3.8 of these. All the appointees were newly qualified and would require preceptorship which would put its own pressures on the ward.

The ward had one consultant psychiatrist who acted as the responsible clinician (RC) for all the patients. She was supported by a junior grade doctor who was full-time on the ward. The ward also had access to an occupational therapist (OT) for two days per week and a physiotherapist for one day per week. We were told that patients who needed to see a psychologist could be referred.

The ward was entered through a locked door into a large atrium that was used as a communal area for patients. There were a number of rooms off this, including the ward office. The male and female bedroom corridors were off either side of this area and were similar in layout. There were doors on the corridor to separate the bedroom area from the communal area, but these were unlocked and open. Each corridor had two larger bedrooms that were more suitable for patients who required mobility support or bariatric equipment. These bedrooms had en suite wet room areas. All of the other bedrooms had en suite toilets, with a communal bathroom and a wet room on each corridor.

**How we completed this review:**

An unannounced visit was made by a Care Quality Commission (CQC) Mental

Health Act reviewer and a CQC inspector. We spoke with a range of staff and informally with patients. We attended a ward round and we reviewed patients' notes and detention documents. We reviewed the policies relating to mixed sex accommodation and to patient observation. We toured the ward. At the end of the visit we fed back to the modern matron.

**What people told us:**

We were unable to interview any of the patients formally. We utilised the short observational framework for inspection to observe patient interactions in communal areas. Staff spoke with patients in a respectful manner and some patients were supported to undertake activities. This included going for a walk in the garden, relaxing and watching TV, chatting and playing a large board game. Patients appeared relaxed and none of the patients we spoke with gave the impression that they were frightened of staff or other patients.

We spoke with a number of staff. We were given a consistent message that staffing numbers on the ward were not adequate to provide the level of care and range of activities that would normally be expected on this type of ward. Staff also told us that the environment on the ward felt very run down and was in need of refurbishment. We were also told by staff that the ward had a reputation for being a stressful area in which to work because of the number of patients who required high levels of observation.

**Past actions identified:**

There were no actions identified from the last visit.

## Domain areas

**Purpose, respect, participation and least restriction:**

The ward was entered by a locked door which required an electronic key to unlock it. Inside this the only locked patient areas that we saw were the main bedrooms that had recently been mopped and were considered to be a slip hazard and the bathrooms. The bedrooms were unlocked once the floor was dry.

The access to the garden was locked and we were told that patients could go into the garden whenever they wanted, but with an escort. The garden was large and had some uneven areas which the staff told us were considered to be trip hazards.

We were told that the use of female bedrooms by male patients was a response to the clinical needs of some of the patients. Initially this was to protect some vulnerable patients from a patient showing some disturbed behaviours, but we were told that as the patients had settled staff were not planning on moving them. We were told that the relatives of the three women who were in the female bedroom

area had been consulted, but not the relatives of the men who had been moved into the area. We were told that the men did not use the bathroom in the female bedroom area, but walked through the communal area to the male bedroom corridor.

We were told of one patient who had not been used to sleeping in a bed, so staff allowed the patient to sleep in a chair and were moving towards getting the patient to sleep in a recliner chair in the bedroom. We considered that this was a good example of managing a person's specific needs.

Care plans that we reviewed were variable in quality and nurse led rather than centred around the needs of the patient. We saw little evidence of patient or carer involvement, although most of the patients were unable to make a significant contribution to the process because of their mental health condition. Care plans appeared to be evaluated on a regular basis, however there was lots of evidence of cut and paste being used and dates were not changed so it was not clear as to which were the latest care plans as older care plans were not cancelled in any way.

None of the bedrooms had the facility for patients to store items securely in a locked cupboard. We were shown a set of labelled plastic boxes stored in a bathroom that were used for the storage of personal items of toiletry.

The observation panels in patients' bedroom doors were routinely open, even when patients were in their rooms. Staff told us that they closed the panels when they were providing personal care to patients.

**Admission to the ward:**

We found a system in place that scrutinised detention documents. All of the detention and renewal documents that we reviewed were fully completed and there were reports from the approved mental health professional (AMHP) for all patients.

We saw records that showed that patients were informed of their rights on admission and at regular intervals following this. The records also showed whether the patient had appeared to understand their rights.

We were told that all qualifying patients were referred to the IMHA service on admission or detention and that the IMHA visited the ward weekly and attended meetings about the patient. We attended the ward round for two patients and there was no IMHA present. We saw no leaflets or posters for the IMHA service. We saw out-of-date posters for the Care Quality Commission, one of which had the wrong contact details. We pointed this out to staff at the time of the visit.

We were told that the ward did not have community meetings because the patients were not able to participate in them. We were also informed that there is no carers group, although staff meet with carers on a one to one basis about their relative.

**Tribunals and hearings:**

We did not review this domain on this visit.

**Leave of absence:**

We saw a system in place for the authorisation and management of leave of absence for detained patients.
On the day of the visit one patient was going home on leave.
A leave form for emergency medical treatment did not specify the level of support that was required by the patient.

We found that section 17 leave was being used appropriately.

**Transfers:**

We did not review this domain on this visit.

**Control and security:**

Staff described a process of distraction, de-escalation and physical intervention that reflected current best practice. We observed the staff routinely interacting at an early stage with patients to prevent distressing situations developing. The records we saw that described physical interventions reflected a level of intervention that was appropriate to the situations described in the notes.

We were told that the male and female lounges also acted as low stimulus environments to support the de-escalation of patients' behaviours. These rooms contained some seating, but were bereft of any décor that might assist with altering a patients presentation.

We were told that the ward did not have access to a seclusion room and did not use seclusion. We found in the notes an episode in which a patient had been secluded in their room for 11 hours two weeks prior to our visit. When we reviewed the notes we found that the staff had recognised that the restrictions that they had placed on the patient amounted to seclusion and put the proper safeguards and recording system in place. We found that this incident of seclusion was managed in line with the guidance in the Code of Practice.

During our visit we saw that the observation levels for several patients was recorded as "constant/15 minutes." Staff explained that this was agreed at the multidisciplinary team (MDT) meeting and allowed observation levels to be increased or reduced when the patient was asleep or where risks varied during waking hours by the nurse in charge of the shift.
In all other circumstances, we were told that the nurse in charge was able to increase the level of observation for a patient, but could only decrease levels of observation ~~it~~ in consultation with a doctor.

We discussed the number of people who were subject to constant observation with the modern matron, particularly in respect of the pressures that this put on the staff team and the effect that this had on the wards ability to support therapeutic activities with patients. This was also a concern expressed by some of the staff we spoke with. We were told that there was a new supportive observation policy in development that changed the way that observation of patients would be carried out. We were told that this would help alleviate some of the problems that we raised as concerns.

We reviewed the organisation's policy for supportive observations and found that, in general, the ward was compliant with the policy. We could not see how the ward was compliant with the policy directive that staff should only be responsible for constant one to one observations for an hour at a time, given the number of patients on the ward who were subject to this level of observation.

We did not see any restrictions on patients' ability to contact family and friends. We were told that maintain patients, relationships with their families was a priority of the ward.

**Consent to treatment:**

For all patients that we reviewed we found that treatment was given under the appropriate legal authority. A second opinion appointed doctor (SOAD) was requested when appropriate. SOAD certificates were legible, correctly completed and copies were placed with the patient's medication card. The use of section 62 to provide emergency treatment was appropriate in all the cases that we saw.

We found assessments of patients' capacity and, where appropriate, formal best interest decisions that covered patients' assessment and treatment.

**General healthcare:**

We were told that the junior doctor on the ward managed the patients' general health care. We saw evidence of actions that reflected the complexity of patients' physical and mental health treatment, with referral for specialist opinion and treatment when appropriate.

**Other areas:**

We were concerned that the staffing levels were barely adequate to manage the group of patients that were on the ward when we visited, given the high level of observation that was required by a number of patients. We observed that this had an impact of the ability of the ward to provide therapeutic activities for the patients and this was confirmed by staff we spoke with. We were told that there was a significant shortfall in the number of registered nurses and that some had been recently appointed. We were told that these were newly qualified nurses requiring preceptorship and recognise that this will place further pressures on the ward.

We found the ward to be in need of redecoration and some refurbishment to bring it up to the standard of environment that is considered to be suitable for caring for people with serious cognitive deficits. We particularly noted the activity room to have peeling and torn wallpaper. We also noted that the corridors were not well lit, considering the higher levels of visual disability and risk of falls within this patient group.

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**<br>Purpose, Respect, Participation, Least Restriction | **CoP Ref:** Chapter 1 |
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**We found:**

That the staffing level for the ward did not allow for the management of higher levels of observation and for planned provision of therapeutic activity and support for section 17 leave for the patients.

That there was a high use of bank and agency staff on the ward, together with staff transferred from other units. These staff are less familiar with the needs of the patients and are less able to support a positive therapeutic environment.

**Your action statement should address:**

How you will ensure that the staffing of the ward will promote a safe a therapeutic environment for the patients in both the short and long term.

The Code of Practice states at paragraph 1.16 “Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate.”

| **Domain 2**<br>Purpose, Respect, Participation, Least Restriction | **CoP Ref:** Chapter 8 |
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**We found:**

That patients did not have access to secure storage for personal items in their bedrooms. We saw personal toiletry items stored in labelled plastic boxes in a bathroom.

The observation panels in the bedroom doors were all open. Staff told us that they would close them when carrying out personal care with a patient. This approach meant that other patients and visitors could see into a patients rooms, even when they were in them.

**Your action statement should address:**

How you will ensure that there is suitable lockable storage for patients' belongings.

How you will manage the use of observation panels in a way that promotes patients' privacy and dignity.

In paragraph 8.24 the Code of Practice states:

> 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, eg razors. Information about arrangements for storage should be easily accessible to patients on the ward.

Paragraph 8.4 states:

> Article 8 of the European Convention on Human Rights (ECHR) requires public authorities to respect a person's right to a private life. Article 8 has particular importance for people detained under the Act. Privacy, safety and dignity are important constituents of a therapeutic environment. Hospital staff should make conscious efforts to respect the privacy and dignity of patients as far as possible, while maintaining safety, including enabling a patient to wash and dress in private, and to send and receive mail, including in electronic formats, without restriction. Respecting patients' privacy encompasses the circumstances in which patients may meet or communicate with people of their choosing in private, including in their own rooms, and the protection of their private property.

| **Domain 2**<br>Purpose, Respect, Participation, Least Restriction | **CoP Ref:** Chapter 1 |
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**We found:**

That the ward environment was run down and did not comply with what is considered to be current best practice in working with patients with dementia. The lighting was poor in places and signage was not appropriate for the patient group.

In places there was wall paper peeling from the wall and the paper had been torn from the wall in other places.

The rooms that were used as low stimulus environments for the de-escalation of aroused patients were bare, rather than being low stimulus.

**Your action statement should address:**

How you will ensure that the environment used for the care of patients is suitable for the task and follows current best practice.

The Code of Practice states at paragraph 1.16 “Patients should be offered treatment and care in environments that are safe for them, staff and any visitors and are supportive and, therapeutic. Practitioners should deliver a range of treatments which focus on positive clinical and personal outcomes, where appropriate.”

| **Domain 2**<br>Purpose, Respect, Participation, Least Restriction | **CoP Ref:** Chapter 8 |
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**We found:**

That bedrooms in the female corridor were used for both female and male patients.

**Your action statement should address:**

How you will assure us that the use of mixed sex accommodation was reported as required by the trust policy on eliminating mixed sex accommodation and the Code of Practice.

How you have ensured that the use of mixed sex accommodation has not put vulnerable patients at risk.

What steps you will take to ensure that the trust use of mixed sex accommodation complies with the guidance from the Department of Health set out in PL/CNO/2010/3

The Code of Practice paragraphs 8.25 and 8.28 state:

> All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients.
>
> If, in an emergency, it is necessary to treat a patient in an environment that does not fully meet their needs, then senior management should be informed, steps should be taken to rectify the situation as soon as possible, and staff should protect the patient's privacy and dignity against intrusions – particularly in sleeping accommodation, toilets and bathrooms.

| **Domain 2**<br>Purpose, Respect, Participation, Least Restriction | **CoP Ref:** Chapter 24 |
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**We found:**

That the quality of care plans was variable and did not always reflect the involvement of the patient, when they were able, or their carers. It was not always clear which was the most up to date care plan. This was a reflection of the generally disorganised state of the case note files.

**Your action statement should address:**

What action you will take to ensure that the standard of care plan is consistent and that it reflects the views of the patient and their carers.

The Code of Practice paragraph 24.47 states: “The treatment plan should form part of a coherent care plan under the CPA (or its equivalent), and be recorded in the patient’s notes.”

The Code of Practice paragraph 24.49 states:

> 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.

The Code of Practice paragraph 24.50 states: “Subject to the normal considerations of patient confidentiality, the treatment plan should also be discussed with their carers, with a view to enabling them to contribute to it and express agreement or disagreement.”

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

## Information for the reader

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| **Author** | Care Quality Commission |
| **Audience** | Providers |
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### Contact details for the Care Quality Commission


**Website:** www.cqc.org.uk

**Telephone:** 03000 616161

**Email:** enquiries@cqc.org.uk

**Postal address:** Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA