Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Townend Court, 298 Cottingham Road, Hull, Humberside. HU6 8QG
Ward(s) visited:	Willow
Ward types(s):	Ward for people with learning disability or autism
Type of visit:	Unannounced
Visit date:	21 June 2016
Visit reference:	36260
Date of issue:	21 July 2016
Date Provider Action Statement to be returned to CQC:	10 August 2016

What is a Mental Health Act monitoring visit?

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. We do this by looking across the whole patient pathway experience from 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Townend Court provides inpatient assessment and treatment for people with a primary diagnosis of learning disability. It is located near the centre of Hull. There are three inpatient wards. Lilac ward provided treatment and Beech ward offered rehabilitation.
We visited Willow ward which was a six-bed male and female admission and assessment unit.
There were three female and three male patients. Four patients (one female and three male) were detained and two patients were informal. One informal patient was on leave. There was no separate female lounge but the space could be reconfigurated to provide one if needed. The ward was locked but the garden area was open.
The seclusion room was not in use on the day of our visit.
There were four healthcare assistants (HCAs) and one registered nurse on duty.
The responsible clinician (RC), a staff grade doctor, the occupational therapist (OT), psychology staff and activities coordinator were also available within Townend Court. A pharmacist attended the multi disciplinary meetings and was involved in monitoring medication management.

How we completed this review:

We made an unannounced visit to the ward. We spoke with a range of staff, looked around the unit, spoke to patients on the ward and met with one patient in private. We looked at the four detained patients' records.

What people told us:

Patients told us they were happy with their care. They said there were plenty of activities. They could talk to the staff who always helped them. They said the food was good.
Staff said the service had improved now they had an OT at Townend Court as well as two activities coordinators who covered seven days per week. They said this made a significant difference to patients' recovery pathway. Staff were happy to work on the unit. Two student nurses were on placement and told us they had been successful in applying for permanent jobs on the ward once they achieved their nursing qualifications.

Past actions identified:

Our last visit was on 30 December 2014 when we found the ward had no ward-based occupational therapy staff. The activities co-ordinator was employed on a part-time

contract. Staff told us they took the lead in organising some patient activities. On this visit we found there were two full time activities coordinators and an OT.

On our last visit we found copies of superseded section 17 leave forms retained in patients' files, which had not been struck through. On this visit this had improved but there were still some gaps in practice.

On our last visit there was no record on the form to show whether the patient or any other relevant person had been given a copy of the leave form. This was still the case and forms an action point below.

Last time we found copies of superseded T2 and T3 forms were retained in patients' medical files without being struck through. This was still the case and forms an action point below.

We found no evidence on our last visit that the RC had discussed the outcome of the second opinion appointed doctors (SOAD) visit with the patient. This was still an issue. We discussed this with the RC during this visit and raise this below.

Other issues from our last visit had been resolved. We found that statutory consultees had not recorded their discussion with the SOAD. This is no longer required by the revised Code of Practice. We also found no evidence that the RC had documented the outcome of a capacity assessment at the end of the three month period following the initial administration of medication for mental disorder. We found evidence on this visit that the RC was documenting the outcome of a capacity assessment at this stage.

Good practice:

Considerations for specific patients

We found comprehensive evidence of full patient involvement in all aspects of care planning. All documents were in easy read format and demonstrated patient input from their admission onwards. Staff took great care to involve patients at all stages and took time to explain everything as often as needed to involve and reassure patients. This practice is in line with the guiding principles of the Code of Practice. The empowerment principle states:

> Patients should be enabled to participate in decision-making as far as they are capable of doing so. Consideration should be given to what assistance or support a patient may need to participate in decision-making and any such assistance or such support should be provided, to ensure maximum involvement possible. This includes being given sufficient information about their care and treatment in a format that is easily understandable to them. (1.10)

Domain areas

Protecting patients' rights and autonomy:

We found evidence that detained patients were given information about their section 132 rights verbally and in easy read format but practice varied in the frequency of repetition. We saw on files evidence that the independent mental health advocate (IMHA) was involved with some patients. Staff told us they referred patients who lacked capacity to the IMHA. They said the IMHA was always responsive to requests for input.

There were separate male and female corridors. All bedrooms were ensuite. Patients could lock their bedroom doors following a risk assessment. On the day of our visit the small lounge was being used to safely care for a male patient. Staff told us they could swop the male and female corridors if vulnerable female patients would benefit from a separate lounge.

There was a ward daily activity programme on display. In addition all patients had their own activity programme. Patients told us there was lots to do on the ward

Assessment, transport and admission to hospital:

We raised issues relating to the detention of one patient on section 5(2) when they attended an outpatient appointment. Staff said the patient had agreed to stay as an informal patient but then changed their mind. However they could not provide evidence of their informal admission prior to the use of section 5(2). The time of admission was noted as 15.15, and the section 5(2) was put in place at 15.15 on the same day.

We asked the trust to seek legal advice about the validity of section 5(2) in these circumstances. They told us their legal advice was that the detention was not legal but the patient's subsequent detention on section 2 and then section 3 was legal as a full assessment process had taken place. Staff took immediate action to complete a report to raise this as a serious untoward incident. They arranged a best interests meeting in order to decide how to inform the patient under the NHS duty of candour.

Additional considerations for specific patients:

We found the provider was taking great care to involve patients with learning disability or autism at all stages of care planning and to ensure patients understood their care plan by using easy read formats.

Care, support and treatment in hospital:

We found care plans demonstrated the patient's involvement. Discharge plans were developed in conjunction with patients. All care plans were provided in easy read format according to patients' needs. Communication and behaviour plans were clear about patient likes and dislikes. Patients were actively encouraged to express their own views at every point in their care. Patients confirmed to us that their views and opinions were actively sought by staff.

We observed staff handling communication with patients with sensitivity, honesty and respect.

We saw on files capacity assessments relating to specific decisions and notes of best interests meetings. We asked why some best interests meetings involved nursing staff only rather than the multi disciplinary team. These did relate to medication matters but staff were surprised that this had happened.

Patients accessed GP services during their stay on the ward. They were invited to attend their weekly reviews. If they did not wish to do so, the RC or their named nurse would meet with them before and after the meeting to keep them informed. The RC did undertake a capacity assessment under section 58 procedures to find out if a patient had capacity to consent to treatment. They requested a second opinion appointed doctor (SOAD) at appropriate times. We found one occasion where the SOAD decided on their visit that the patient did have capacity, and the RC completed form T2. We did not find evidence that the RC discussed the outcome of SOAD visits with the patient as required by the Code of Practice. We discussed this with the RC.

We were concerned to find that in one case the SOAD's visit took place on 15 April 2016 but the T3 was dated 12 May 2016. We asked the RC how the medication was authorised between those dates as we could not find authorisation for section 62 treatment. We reminded the RC and nursing staff of their duty to ensure that medication that is prescribed and administered is duly authorised. We found some old T2s and T3s were not crossed out to avoid mistakes being made. We raise these issues as an action point below.

We looked at the seclusion records for one patient who had been secluded for one long and a few short periods. We found that nursing and medical reviews did not meet the requirements of the Code of Practice and the trust's own policy. Some reviews were missing, some were not dated or did not have the review time on them and one nursing review was undertaken by a registered nurse and an HCA. We asked what audit procedures were in place to review seclusion and ensure compliance with the Code. Staff on duty could not answer the question. We raise this as an action point below.

Leaving hospital:
Discharge plans were in evidence in all files. They were embryonic in the early stages of admission but addressed the likelihood of a patient's returning to their previous placement and the patient's views. We did not find evidence that patients and other involved parties were given copies of their section 17 leave forms. Although most superseded section 17 leave forms were crossed out, there were still some gaps.
Professional responsibilities:
The processes for receipt and scrutiny of documents had failed to see that a patient who was not admitted to the ward had been placed on section 5(2). Staff were not aware of the legality issues in this case. They had not received training on the Mental Health Act. However they took immediate action to seek legal advice and to report the matter for a serious untoward incident investigation. They also arranged a best interests meeting to decide what information to give the patient and how to do so, in line with their duty of candour.
Other areas:
We did not review any other areas.

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**	**MHA section:** 132 **CoP Ref:** Chapters 4, 37
We found:	
We found evidence that detained patients were given information about their section 132 rights verbally and in easy read format but practice varied in the frequency of repetition.	
Your action statement should address:	
What action you will take to audit compliance with the Code of Practice which states: "The organisation (or individual) concerned should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf." (37.11)	

Domain 2 **Assessment, transport and admission to hospital**	**MHA section:** 5 **CoP Ref:** Chapter 37

We found:

Issues relating to the detention of one patient on section 5(2) when they attended an outpatient appointment. Staff said the patient had agreed to stay as an informal patient but then changed their mind. However they could not provide evidence of their informal admission prior to the use of section 5(2). The time of admission was noted as 15.15, and the section 5(2) was put in place at 15.15 on the same day.

Staff took immediate action to seek legal advice that stated the original detention of the patient on section 5(2) was not legal but they were now legally detained on section 3 after a full assessment. Staff raised the matter as a serious untoward incident and arranged a best interests meeting to discuss how to inform the patient under their duty of candour.

Your action statement should address:

What steps were taken in relation to the patient concerned.

What steps you have taken to ensure that scrutiny processes are robust in compliance with the Code of Practice which states:
“Organisations (or individuals) in charge of hospitals retain responsibility for the performance of all hospital managers’ functions exercised on their behalf and must ensure that people acting on their behalf are competent to do so.” (37.10)

And
“It is the hospital managers’ responsibility to ensure that the authority for detaining patients is valid and that any relevant documents are in order.” (37.12)

Domain 2 Care, support and treatment in hospital	MHA section: 58 CoP Ref: Chapter 25

We found:

On one file the SOAD's visit took place on 15 April 2016 but the T3 was dated 12 May 2016. We asked the RC how the medication was authorised between those dates as we could not find authorisation for section 62 treatment. We reminded the RC and nursing staff of their duty to ensure that medication that is prescribed and administered is duly authorised.

We found some old T2s and T3s were not crossed out to avoid mistakes being made.

Your action statement should address:

What evidence you have that the patients medication was duly authorised between 15 April 2016 and 12 May 2016 as required by the Code of Practice which states:

> Section 58 applies only to detained patients. They cannot be given medication to which Section 58 applies unless:
> the approved clinician in charge of treatment, or a SOAD, certifies that the patient has capacity to consent and has done so, or
> a SOAD certifies that the treatment is appropriate and either that:
> the patient does not have the capacity to consent, or
> the patient has the capacity to consent but has refused to do so (25.14)

What steps you have taken to ensure that all invalid T2s and T3s are marked as invalid to avoid potential for mistakes to be made.

Domain 2 **Care, support and treatment in hospital**	**MHA section:** 58 **CoP Ref:** Chapter 25

We found:

No evidence that the RC discussed the outcome of SOAD visits with the patient as required by the Code of Practice. We discussed this with the RC.

Your action statement should address:

What steps you will take to ensure that RCs act in line with the Code of Practice which states:

"It is the personal responsibility of the clinician in charge of treatment to communicate the results of the SOAD visit to the patient. (25.66)
And

"The clinician in charge of the treatment should record their actions in providing patients with (or withholding) the reasons supplied by the SOAD." (25.67)

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

We found:

Nursing and medical reviews in the seclusion records for one patient did not meet the requirements of the Code of Practice and the trust's own policy. Some reviews were missing, some were not dated or did not have the review time on them and one nursing review was undertaken by a registered nurse and an HCA.

Your action statement should address:

What audit procedures are in place to review seclusion and ensure compliance with Chapter 26 of the Code of Practice and the trust's policy.

Domain 2 **Leaving hospital**	**MHA section:** 17 **CoP Ref:** Chapter 27
We found:	
No evidence that patients or involved parties were given copies of section 17 leave forms	
Your action statement should address:	
What steps you have taken to provide evidence that patients and other relevant parties are given copies of section 17 leave forms as required by the Code of Practice which states: “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” (27.18)	

During our visit, 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	A
Issue:	
The patient told us they had been involved in an incident on Beech ward which led to their transfer to Willow ward. They wished to know when they could transfer back to Beech ward and have section 17 leave. The staff nurse joined us to discuss this with the patient.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
Author	Care Quality Commission
Audience	Providers
Copyright	

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