Mental Health Act 1983 monitoring visit

Provider:	Humber NHS Foundation Trust
Nominated individual:	Hilary Gledhill
Region:	North
Location name:	Townend Court
Ward(s) visited:	Lilac
Ward types(s):	Ward for people with learning disability or autism
Type of visit:	Unannounced
Visit date:	2 February 2017
Visit reference:	37328
Date of issue:	2 March 2017
Date Provider Action Statement to be returned to CQC:	22 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Lilac ward is an assessment and treatment ward for people with learning disabilities at Townend Court in Hull.

On the day of our visit there were seven patients allocated to the ward, three patients were detained under the Mental Health Act 1983 (MHA). All other patients were subject to Deprivation of Liberty Safeguards (DoLS).

Staff told us baseline staffing for the ward was one deputy nurse, one qualified nurse and three healthcare assistants on a day shift. On a night shift baseline staffing was one qualified nurse and two healthcare assistants. Staff worked long day shift patterns. Staff told us they did not use agency staff on the ward and bank staff were used when there was a high level of clinical activity or staff sickness.

On the day of our visit there were two qualified nurses on shift. One was a deputy ward manager and three were healthcare assistants.

The unit had one consultant psychiatrist who was supported by junior medical staff, who provided medical care. In addition the ward had access to occupational therapy, speech and language therapy and psychology services.

How we completed this review:

This was a routine unannounced visit to the ward by a Mental Health Act Reviewer (MHAR) and an inspector who was shadowing the MHAR. On arrival at the ward we met with the deputy ward manager and a qualified nurse.

We introduced ourselves to all three detained patients and met with each individually. Two we met with chose to see us in the presence of staff and one patient met us in private. Other patient's subject to DoLS authorisations were told by staff we were visiting the ward.

We had a tour of the ward and one patient showed us their bedroom. Three patient engagement forms were returned completed.

We reviewed all three detained patients' records.

We provided verbal feedback to the modern matron for the service, service manager and consultant psychiatrist for the ward at the end of our visit.

What people told us:

All patients we met spoke positively about staff “staff are ok”, “see doctor enough”, “the staff are ok here”, “staff are ok but busy” and “don’t like to approach staff when they are busy”.

Patients told us their privacy was respected and felt they were treated with respect. Patients told us that they felt there were enough activities available. All patients we met told us they were happy with their rooms and had no concerns with them. No patients raised any worries or concerns that we met.

Three patient engagement forms were completed and all indicated they were happy with their care plans, medication, information on rights, environment, food and communication. One patient wrote they would like to play more pool on the ward. Another patient had written they were not sure of their discharge plan as plans were not fully decided. One patient had written on their form that they felt safe on the ward ‘sometimes’.

We spoke with staff informally throughout the day. Staff told us they received supervision and mandatory training. Staff did not raise any issues. Staff told us there had been recent training sessions held on the ward regarding the seclusion policy as this had been updated.

Past actions identified:

The previous MHA monitoring visit was on 24 August 2015. The following issues were identified:

- Assessments of capacity to consent to treatment were not completed for two detained patients in accordance with the Code of Practice (2015)

This issue had been resolved.

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

This issue had been resolved.

Domain areas

Protecting patients' rights and autonomy:

The unit was entered through a locked door. Patients were required to ask staff if they wished to leave the ward and this would then be assessed dependent upon their leave status.

Patients were able to access fresh air in the enclosed garden and doors to this area were unlocked. Patients were able to smoke in the garden and we observed throughout our visit patients regularly accessed the garden area.

Patients had access to their bedrooms at any time but were required to ask staff to open their bedrooms. We found no patient on the ward on the day of the visit had a key to their room. Staff on the ward told us that patients were risk assessed as to whether they could have their bedroom key. We did not find record of this on the three patient files reviewed. We did not find a 'key agreement plan' on file for any of the records reviewed or this information contained in their risk assessments. This was a blanket restriction and the impact was not considered individually in line with the Code of Practice (2015).

Patients' access to hot drinks and kitchen facilities was restricted as the room was locked and required patients to ask staff to access this. Staff told us that patients were individually risk assessed to determine whether they could make their own hot drinks and use the kitchen area. We did not find records of individual risk assessments around kitchen access on the three patients' records we reviewed and found this to be a further blanket restriction.

We found the ward was identifying any restrictive practices and noting these down each day, but we did not find the above to be restrictions noted on the handovers. The restrictive practices noted were the locked door and access to lighters.

We found there was no information on display to patients about how to complain, how to contact the Independent Mental Health Advocacy service (IMHA) or how to contact the Care Quality Commission (CQC). Staff showed us some information in a cupboard on the ward but this was not easily accessible as it was amongst lots of other information. Patients would not easily know to find the information in there. Staff told us that information was provided to patients in a welcome pack on admission.

Staff told us Independent Mental Health Advocates (IMHA) came to the ward. Staff told us referrals were automatically made to the IMHA service on admission for patients, when requested by patients, or that patients could self-refer. Staff and patients confirmed there was timely access to the IMHA service. Staff told us they were unaware if the ward monitored the use of the IMHA service such as recording the amount of referrals made to the IMHA service.

Patients had access to their own mobile phones on the ward unless there was a risk

issue and they would then be supported through an individual care plan. We found that patients had no personal access to the internet on the ward. There was no policy in place regarding patients' access to the internet. Staff told us patients could use their own data on their mobile phones to access the internet but there was no Wi-Fi available for patients to access, or computers on the ward.

Male and female sleeping areas were segregated in line with the revised Code of Practice (2015). However we found there was no female only lounge. There were two lounge areas which were available for use by both male and female patients.

Staff told us that there was no direct carer support offered from the ward or at Townsend court. There was no carer lead/champion identified on the ward. Staff told us that information is shared with carers where possible and they were invited to multi-disciplinary team (MDT) meetings where possible, subject to the patients consent.

We found on the three records reviewed, that all patients had been informed of their section 132 rights. We found section 132 rights were read on admission and then revisited. Patients were provided information about their section 132 rights in easy read format

Assessment, transport and admission to hospital:

Detention documents were available for scrutiny. This documentation contained the required legal criteria for detention. On all of the records reviewed Approved Mental Health Professional (AMHP) reports were available where required.

Staff told us patients were usually admitted to the ward from the assessment ward in Townsend Court or straight to the ward from the community. The ward was primarily a treatment ward at Townsend Court, but staff told us that patients could be admitted to the ward if they were assessed as being more suitable for that ward. Patient mix on the wards was also considered.

Additional considerations for specific patients:

We saw a range of symbols were posted throughout the ward to aid patient recognition.

Qualified nurses on the ward had completed training in learning disability. Staff told us there were also e-learning courses available at the university which covered learning disability and autism.

Care, support and treatment in hospital:

Patients remained registered with their local general practitioner (GP) unless they were not local to the area and would be registered with a local GP. Staff told us there were no difficulties accessing GP services. The local walk in centres are accessible if needed. We did not find a physical health assessment completed on three of the patient records reviewed. Staff told us these were completed on admission. However, on one of the files we reviewed, we found the patient had been offered a physical health check but declined it and it was unclear when this was revisited.

Multi-disciplinary team (MDT) meetings took place every week. Patients were encouraged to attend their MDTs and their wider community teams were invited.

There was no seclusion room on the ward but we found when seclusion was required a neighbouring ward's seclusion room would be used.

We found one patient had been secluded in January 2017. We reviewed the seclusion records for this patient. We found a number of issues with the seclusion review. The seclusion had commenced at 11pm. We found the first two hourly nursing review was half an hour late. We found there was no further nursing review which was due at 3am.

The medical review was not completed within four hours. The nurse who made the decision to seclude the patient did not take the lead with the seclusion. There were conflicting entries from the doctor and nurse regarding the ending of seclusion.

Therefore there was no clear evidence that seclusion had been terminated appropriately by the nurse with the doctor or by the responsible clinician. The medic's entry at 4.10am recorded that nursing staff would continue to monitor the patient in seclusion. There was then a further entry which indicated that nurses had ended seclusion at 4.15am. There was no record of seclusion management reviews or rationale for ending seclusion on the electronic recording system.

A seclusion audit had been completed and identified some of the issues noted above. However, the audit tool had indicated that nursing reviews had taken place at two hourly intervals when this was not documented in the patient's clinical records.

We found the activities board to be empty so it was not clear what activities were available to patients. Staff and patients told us that activities took place. There was one activities worker at Townend Court who was full time and worked over seven days to provide activities. Staff told us they were supervised by the Occupational Therapist. Staff told us there was another activities coordinator but they were on maternity leave. On the day of our visit there was a bowling group taking place which patients was invited to attend.

On the three patients records we reviewed, all had up to date care plans in place.

Care plans were individualised and regularly reviewed. It was difficult to find record of the level of patient involvement in care plan reviews. Patients told us they regularly saw their care plans.

Staff reported that they were aware of safeguarding policies and procedures and would make referrals to safeguarding adults and children as appropriate.

Leaving hospital:

In the three records checked two patients had section 17 leave in place.

We found leave was discussed in the MDT and that appeared to be the forum where risk assessment would take place and the responsible clinician (RC) would take the decision to approve or decline leave. Patients signed their leave authorisation forms and received a copy.

The section 17 leave authorisation forms did not indicate if relevant others received a copy of the form. We found some old section 17 forms on file which had not been cancelled or struck through.

The outcome of section 17 leaves was documented on patient's records.

We were told discharges were usually into the community, supported accommodation or longer term care if required.

Professional responsibilities:

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

There were systems in place to scrutinise documents after a patient had been admitted to the ward. We were told the MHA office would check records.

The ward completed an MHA audit regularly of patient's records.

Staff told us there was learning from incidents and this was mainly shared through emails to staff and through supervision. Debriefs took place with involvement from psychology following any untoward incident on the ward.

Other areas:

No other areas to report on the visit.

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:** **CoP Ref:** Chapter 8
We found:	
We found that patients had no personal access to the internet on the ward. There was no policy in place regarding patient access to the internet.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraphs: 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." 8.16 "Communication with family and friends is integral to a patients care and hospitals should make every effort to support the patient in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media. Providers should, however, provide patients access to a coin or card operated phone."	

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

We found:

Patients had access to their bedrooms at any time but were required to ask staff to open their bedrooms. We found no patient on the ward on the day of the visit had a key to their room. Staff on the ward told us that patients are risk assessed as to whether they could have their bedroom key. We did not find record of this on the three patient files reviewed. We did not find a 'key agreement plan' on file for any of the records reviewed or this information contained in their risk assessments. This was a blanket restriction and the impact not considered individually in line with the Code of Practice (2015).

Patient's access to hot drinks and kitchen facilities was restricted as the room was locked and required patients to ask staff to access this. Staff told us that patients were individually risk assessed whether they could make their own hot drinks and use the kitchen area. We did not find record of individual risk assessments around kitchen access on the three patients records reviewed and found this to be a further blanket restriction.

Your action statement should address:

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

> 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 Protecting patients' rights and autonomy	MHA section: CoP Ref: Chapter 4
We found:	
We found there was no information on display to patients about how to complain, how to contact the Independent Mental Health Advocacy service (IMHA) or how to contact the Care Quality Commission (CQC).	
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: CoP Ref: Chapter 8
We found:	
We found there was no female only lounge.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraph: 8.25 "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."	

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

We found:

Staff told us that there was no current direct carer support offered from the ward or at Townsend Court. There was no carer lead/champion identified on the ward.

Your action statement should address:

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

> 4.42 "Carers are key partners with health and care services and local authorities in providing care, especially for relatives and friends who have mental disorders. In many instances, especially when a patient is not in hospital, the patient's carers and wider family will provide more care and support than health and social care professionals. It is important for professionals to identify all individuals who provide care and support for patients, to ensure that health and care services assess those carers' needs and, where relevant, provide support to meet them. Local authorities also have duties in the Care Act 2014 to assess adult carers' current and future needs for support and, must meet eligible needs for support. The Children and Families Act 2014 also places a duty on local authorities to assess needs for support of both parent carers of disabled children and young carers."
>
> 4.44 "In order to ensure that carers can, where appropriate, participate fully in decision making, it is important that they have access to:
> - practical and emotional help and support to assist them in participating, and
> - timely access to comprehensive, up-to-date and accurate information."

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

We found:

We did not find a physical health assessment completed on three of the patient records reviewed. Staff told us these were completed on admission. However, on one of the files reviewed we found the patient had been offered a physical health check but declined it and it was unclear when this was revisited

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.”
>
> And
>
> 24.57 “Commissioners and providers should ensure that patients with a mental disorder receive physical healthcare that is equivalent to that received by people without a mental disorder. The physical needs of patients should be assessed routinely alongside their psychological needs. Commissioners need to ensure that long term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral.”

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

We found:

We found one patient had been secluded last month. We reviewed the seclusion records for this patient. We found a number of issues with the seclusion review. The seclusion had commenced at 11pm. We found the first two hourly nursing review was half an hour late. We found there was no further nursing review which was due at 3am.

The medical review was not completed within four hours. The nurse who made the decision to seclude the patient did not take the lead with the seclusion. There was conflicting entries from the medic and nurse regarding the exit of seclusion.

Therefore there was no clear evidence that seclusion had been terminated appropriately by the nurse with the doctor or by the responsible clinician. The medic's entry at 4.10am recorded to continue to monitor the patient in seclusion and then an entry indicated nurses had ended seclusion at 4.15am. There was no record of seclusion management reviews or exit rational on the electronic recording system.

A seclusion audit had been completed and identified some of the issues noted above. However, the audit tool had indicated that nursing reviews had taken place at two hourly intervals when this was not documented in the patient's clinical records.

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."
>
> 26.144 "Seclusion should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patients' responsible clinician or duty doctor. This consultation may take place in person or by telephone."

Domain 2 Leaving Hospital	MHA section: CoP Ref: Chapter 27
We found:	
The section 17 leave authorisation forms did not indicate if relevant others received a copy of the form. We found some old section 17 forms on file which had not been cancelled or struck through.	
Your action statement should address:	
How you will demonstrate adherence with the following Code of Practice (2015) paragraph: 27.22 “Hospital managers should establish a standardised system by which responsible clinicians can record the leave they authorise and specify the conditions attached to it. Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know. A copy should also be kept in the patients notes. In case they fail to return from leave, an up to date description of the patient should be available in their notes. A photograph of the patient should also be included in their notes, if necessary with the patients consent (or if the patient lacks capacity to decide whether to consent, a photograph is taken in accordance with the Mental Capacity Act (MCA)).”	

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	C
Issue:	
Patient C told us they would like to do some fundraising work for a charity and would like to discuss this with staff. We asked staff to meet with the patient to consider this. Please meet with this patient and update us of the outcome.	

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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