Mental Health Act Annual Statement January 2010

Humber Mental Health Teaching NHS Trust

Introduction

The Care Quality Commission (CQC) visits all places where patients are detained under the Mental Health Act 1983. Mental Health Act Commissioners meet and talk with detained patients in private and also talk with staff and managers about how services are provided. As part of the routine visit programme information is recorded relating to:

- Basic Factual details for each ward visited, including function, bed occupancy, staffing, and the age range, ethnicity and gender of detained patients.

- Ward Environment and Culture, including physical environment, patient privacy and dignity, safety, choice/access to services/therapies, physical health checks, food, and staff/patient interaction.

- Issues raised by patients and patient views of the service provided, from both private conversations with detained patients and any other patient contacts made during the course of the visit.

- Legal and other statutory matters, including the scrutiny of Mental Health Act documentation, adherence to the Code of Practice, systems that support the operation of the Act and records relating to the care and treatment of detained patients.

Following each visit a “feedback summary” is issued to the Trust identifying any areas requiring attention. The summary may also include observations about service developments and/or good practice. Areas requiring attention are listed and the Trust is asked to respond stating what action has been taken. The response is assessed and followed up if further information is required. The information is used by the CQC when making decisions about the inspection programme in the Public Sector. In future years it will be used to inform registration decisions.

A list of the wards visited within this Trust is provided at Appendix A.

Background

Humber Mental Health Teaching NHS Trust manages a number of units covering the city of Hull and surrounding area of East Yorkshire. Most of the Trust’s facilities are located within Hull itself, with a small but reducing number of facilities further afield. The Trust provides a range of Mental Health and Learning Disability services for both informal and detained patients.

This statement draws on findings from visits by Mental Health Act Commissioners both under the auspices of the Mental Health Act Commission and those which took

place after April 1 2009 when the functions of the Mental Health Act Commission were taken over by the Care Quality Commission.

The Annual Statement provides an overview of the main findings from visiting, highlighting any matters for further attention and / or areas of best practice. It is published on the CQC website, together with other publications relating to individual mental health providers.

Main findings
Relations between Mental Health Act Commissioners and managers of the Trust have remained constructive throughout the reporting period.

Following receipt of feedback summaries from the programme of visits, the Trust's responses to the issues raised were generally completed and forwarded to the CQC, although at the time of writing this statement, some of the feedback documents are awaited by the CQC. It was encouraging to note that clearly defined action points and time scales were included in the Trust's responses and these will be followed up on future Mental Health Act Commissioner visits. Much work has been done to improve the environments in which patients are cared for over the course of this visiting period.

Mental Health Act and Code of Practice
In the Annual Report published by the Mental Health Act Commission in 2008 there were eight recommendations;

Recommendation 1
Following a renewal of detention by an Associate Specialist grade doctor, the Trust was asked to review its procedures in relation to renewal of detention and advise the Commission whether these fulfilled the requirements of Section 20 of the Act.

Recommendation 2
In a Trust audit in May 2008 of Section 132 compliance only one unit achieved 100%. The Trust was recommended to repeat the audit with consideration given to auditing the same units to determine the effectiveness of action plans, or auditing the remaining units to gain a full picture of compliance across the Trust. The Commission asked that the results and action plans were again forwarded as with the initial audit.

Recommendation 3
The Commission recommended that the Trust carry out an audit on all aspects of Section 17 Leave of Absence, similar to that for Section 132 and again, to forward the findings and action plan to the Commission.

Recommendation 4
Of a more urgent nature, following concerns regarding the use of Section 17 at the Humber Centre, the Trust was asked to examine the overall provision of Section 17 Leave in this unit in order that patients have Leave opportunities facilitated at appropriate times in their journey in support of moving forward to more open facilities as part of the recovery process. The Commission asked that a report detailing findings and actions to improve Section 17 Leave provision be forwarded.

Recommendation 5
The Commission asked that the Trust expedite the planned environmental improvements to identified units, and in addition identify action to be taken to reduce the ligature risks found by Commissioners. The Commission asked for an update on progress on these issues.

Recommendation 6
The Trust was asked, as a matter of priority, to address the staffing levels across the Humber Centre and additionally look at how current staff across those units are supported in what can be a stressful work environment. The Trust was asked to forward to the Commission a report and action plan to address these issues.
In addition, the Trust was asked to expedite the planned environmental changes at the Humber Centre which staff have identified would help to alleviate some of the pressures of the unit. The Commission asked for an update on the time scale for completion of this work.

Recommendation 7
The Trust was asked to ensure that advocacy services are available for all patients across the range of facilities. The Commission also requested an update on the Trust's preparation for the Independent Mental Health Advocate requirement from April 2009 under the amendments to the Act.

Recommendation 8
The Commission asked that the Trust provide an outline of its plans to comply with the duty to provide age appropriate services with effect from April 2010.

At the time of publication of the 2008 report, the Trust had not yet provided their action plan in response to the above recommendations.

2009 visit programme
The following points highlight those Mental Health Act issues raised by visiting Commissioners in 2009. The detailed evidence to support them has already been shared with the Trust and is not rehearsed here. For further information about these findings please contact the author of this report via the Care Quality Commission at the Nottingham office.

Detention
In general, the detention documentation examined across most of the Trust's facilities was found to be in good order. However, a significant issue arose in relation to completion of the H5 Renewal of Authority for Detention form. This issue related to the date inserted in the 'Patient is liable to be detained for a period ending on' section. The Responsible Clinician (RC) had inserted the date of expiry of the renewal rather than the current period of detention. This affected the renewal of detention for eleven patients on a number of units, who were informed that their detention was not legal and were subsequently detained under Section 5(2) leading to new Section 3 assessments. The Commissioner expressed surprise that the Care Quality Commission had not been informed of such a significant issue and the Trust's Mental Health Act Administrator has subsequently updated the CQC with the relevant information. The particular issue has been addressed by the Trust and is not considered to be an ingoing systemic problem.

One restricted patient's authority for transfer between units within the Trust could not be found by the Commissioner, staff, Mental Health Act Administration office or RC's office. A copy of the relevant authorisation was obtained from the Ministry of Justice three days after the visit.

Section 58
Most of the treatment cards and associated authorisation forms were found to be correct. Some individual issues were found, including unauthorised medication prescribed, maximum daily dose not identified on the card, authorisation forms not with treatment cards and consent discussions between RC and patient not reflecting the code of practice guidance.

Commissioners have found that Trust-wide, the mechanism for prescribing oral and intramuscular forms of the same medication (usually lorazepam or haloperidol), predominantly for PRN or 'as required' administration, could lead to patients being given more than the maximum allowed dose. Staff on several units were unaware of the difference in British National Formulary (BNF) maximum doses of oral and intramuscular haloperidol, which could lead to patients receiving in excess of BNF maximum doses of the intramuscular form.

A point of good practice across some units within the Trust is the adoption of a checklist to accompany treatment under Part IV of the Act. This checklist covers the areas in which mistakes or misunderstandings can occur. However, it was noted by Commissioners that the checklist was, on a small number of occasions, incorrectly completed, which rendered the checklist ineffective.

Section 132
Following last year's audit of Section 132 compliance the Trust put in place procedures to ensure improved compliance and evidence of patient involvement.

Compliance with Section 132 was indeed found by Commissioners to be improved and is good in terms of the regularity of explanations for patients and forms being signed by the patient. There was some inconsistency in documenting the discussions of rights with patients in their notes, identifying the patient's level of understanding and necessary frequency based upon individual need.

As with the good practice point in Section 58 above, some units within the Trust include a capacity checklist with the Section 132 form.

Section 17
Practice in relation to Section 17 Leave of Absence was found to be good across most of the units within the Trust. Evidence of patient involvement is inconsistent across the units, with some units which clearly involve the patient in decisions about Section 17 leave, with patient signatures consistently recorded, and other units on which no evidence could be found. Commissioners expressed concern that some Section 17 leave authorisations are written for 12 month periods. The Code of Practice recommends that Responsible Clinicians regularly review any Section 17 leave they authorise and the CQC would question whether annual reviews are regular enough. For a small number of restricted patients, documentation relating to Section 17 leave could not be immediately sourced by Commissioners or staff.

Other issues raised from Mental Health Act visiting activity

The physical environment

Many of the Trust's facilities have undergone significant environmental improvements as part of an ongoing refurbishment programme. Improvements have been observed by visiting Commissioners and the positive benefits identified by staff and patients. Whilst there is still refurbishment work to be done, the Trust's commitment to improving patient environments was clear to Commissioners during this visiting period.

There are still some units which have bedroom doors with inappropriate viewing facilities, with patients' privacy and dignity seriously compromised on units which have a clear glass panel in the bedroom doors with no means of effecting privacy from other patients or visitors to the unit.

The Trust is working hard towards single gender unit provision. Westlands is now a female only unit and New Bridges is all male. Other units have clearly defined gender specific areas.

A new unit is being built as an addition to the Humber Centre site. This is scheduled to open in early 2010 and will provide services for those with personality disorders and with learning disabilities. Commissioners were informed of the involvement of current patients in the design and decor of the new wards at all stages of development – practice which is commendable.

Advocacy

Advocacy is well provided for across the units, with a range of providers involved with the specific type of client group with which they specialise. The Independent Mental Health Advocacy (IMHA) requirement, introduced as part of the amendments to the Mental Health Act, is being fulfilled. Initially the IMHAs were attending wards on a weekly basis, a significant commitment across a sizeable Trust, but are now involved with patients on an individual referral basis.

Deaths of detained patients reported to CQC

During this reporting period two deaths of detained patients have been reported to the Commission, both of which were ruled by the Coroner as natural causes.

Complaints

Four complaints have been reported to the Commission in this reporting period. All related to the treatment each of the four complainants had been receiving. All four have been investigated by the Trust and are now closed.

Recommendations for Action

Detention

The Trust must ensure that any patients affected by the aforementioned renewal date error are informed of both their current status and their rights in relation to consent to treatment (new commencement of three month rule) and referral to the Mental Health Review Tribunal during the new first period of detention.

Additionally the Trust must ensure that copies of relevant documentation are filed in patients' notes, with particular regard to restricted patients, in order that staff are assured and can evidence that patients are appropriately detained within their unit.

Section 58

The CQC would urge the Trust to address the issue of prescribing both oral and intramuscular forms of the same medications in terms of ensuring the maximum daily dosage is both clearly defined and unambiguous. Whilst oral and intramuscular forms of medication are always appropriately separately prescribed, the maximum daily dose is not always clearly defined or easy to read on the prescription chart. The managers across the Trust's units who spoke with the Commissioners about this issue indicated that they would discuss the issue with the pharmacists in order to design a consistent system.

The Trust must ensure consistency in documented discussions between the RC and patient about consent to treatment issues. The Code of Practice is explicit in what should be discussed with the patient and documented in their clinical record.

The Trust should ensure that all consent to treatment forms are accompanied by the good practice checklist found on some units and that they are properly completed. This will serve to reduce the occurrence of errors in relation to Part IV of the Act.

Sections 132 and 17

Section 132 compliance is generally good across the Trust, but could be improved by better evidencing of patient involvement and understanding. The capacity checklist found on some units and used in conjunction with Section 132 documentation should be implemented across all areas in which patients are detained under the Act.

The Trust should ensure that the good Section 17 practice found on some units is replicated in those areas where Commissioners found little evidence of patient involvement. The Trust should also consider whether an annual renewal of Section 17 authorisation is regular enough in terms of Code of Practice compliance.

Environmental issues

The Trust must urgently look at the privacy and dignity issue raised above in relation to observation of patients by other patients or visitors through clear glass panels in bedroom doors. Feedback from the Trust indicates that this is being reviewed and the CQC asks that an update be forwarded at the earliest opportunity.

Forward Plan

Mental Health Act Commissioners will continue to visit all of the Humber Trust facilities for detained patients as part of the visiting programme, to monitor the operation of the Act and to meet with detained patients in private.

They will continue to work with other colleagues in the Care Quality Commission to develop an integrated approach to the regulation of the Trust's services.

Appendix A: List of wards visited at Humber Mental Health Teaching NHS Trust

Date	Ward	Detained patients seen	Records checked
West End Community Mental Health Adolescent Unit			
28 Aug 2009	Adolescent Unit	0	0
Total for West End Community Mental Health		**0**	**0**
Townend Court			
30 Apr 2009	Ridings	1	1
20 May 2009	County	2	3
	Shire Unit	0	0
Total for Townend Court		**3**	**4**
Bridlington & District Hospital			
24 Apr 2009	Buckrose	2	3
Total for Bridlington & District Hospital		**2**	**3**
Aysgarth House			
30 Apr 2009	Aysgarth House	0	0
Total for Aysgarth House		**0**	**0**
Westlands			
28 Aug 2009	Westlands	1	3
Total for Westlands		**1**	**3**
Humber Centre Forensic Unit			
12 Mar 2009	Derwent	2	1
	Ouse	2	3
	Trent	1	2
1 Oct 2009	Trent	2	4
Total for Humber Centre Forensic Unit		**7**	**10**
Maister Lodge			
8 Oct 2009	Maister Lodge	1	5
Total for Maister Lodge		**1**	**5**
Hawthorne Court			
25 Sep 2009	Hawthorne Court	0	3
Total for Hawthorne Court		**0**	**3**
Mill View			
18 Jun 2009	Mill View Court	1	4
	Mill View Lodge	0	1
Total for Mill View		**1**	**5**

Date	Ward	Detained patients seen	Records checked
Miranda House			
31 Mar 2009	PICU	2	4
Total for Miranda House		**2**	**4**
Greentrees Lodge			
11 Aug 2009	Greentrees	5	3
Total for Greentrees Lodge		**5**	**3**
St Andrews Place			
22 Jul 2009	St Andrews Place	2	3
Total for St Andrews Place		**2**	**3**
South West Lodge			
11 Aug 2009	South West Lodge	1	0
Total for South West Lodge		**1**	**0**

Total Number of Visits: 15
Total Number of Wards visited: 18
Total number of Patients seen: 25
Total Number of documents checked: 43