Mental Health Bulletin

May 2015

Introduction

Welcome to this first edition of CQC's *Mental Health Bulletin* which we hope will help our work to encourage provider services to improve. In these bulletins we highlight some of the themes arising from recent inspections and flag up examples we have found of good practice.

We will also let you know about new 'brief guides' that we have developed on specific issues that we encounter repeatedly when we inspect. These are designed primarily to guide our inspection teams. However, we thought that they might also be of interest to providers because they set out our position on the topic in question.

Every provider is unique. Local knowledge of the specific risks that you face, how these should be prioritised and what local solutions would work best should always take precedence but we hope that these short articles will be of interest.

Seclusion

On some psychiatric wards that we have inspected staff have not understood what constitutes seclusion. The Mental Health Act (MHA) code of practice defines it as "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of containment of severe behavioural disturbance which is likely to cause harm to others".

On some wards, staff had been escorting disturbed patients to a specific room where they were isolated from other patients and prevented from leaving. This constitutes seclusion. However staff had not recognised or recorded it as such. The necessary safeguards associated with seclusion set out in the MHA code of practice were not put in place to protect the patient.

We have also inspected wards where, although staff recognise that they are using seclusion, they have not put in place the necessary safeguards. The code

of practice sets out specific requirements for how seclusion should be recorded, monitored and reviewed. On some wards, the record of this information was missing or incomplete, or there was no formal mechanism for it to be recorded.

In the absence of a complete record, neither ward staff, provider managers nor the CQC can be certain that the actions necessary to protect the safety and human rights of the patent have been taken.

We have seen good examples where a seclusion log or register was maintained. This contained all the appropriate information around the seclusion including (but was not limited to) the reasons for the seclusion and how it had been monitored and reviewed in line with the code of practice. It was sufficiently detailed to enable senior staff to review the seclusion episodes.

Incidents and near misses

Providers must be able to demonstrate that they learn from incidents and near misses. This is important for patient safety and the CQC uses it as an indicator that a service is well-led. Not all providers that we have inspected had good systems for reporting incidents and learning from these.

In some of the providers we have inspected, front line staff knew what constituted an incident or a near miss. They knew what to report, how to report and did so promptly. The system for reporting was easy to use. Their reports were reviewed by senior staff in a timely fashion and the root causes were identified. Managers ensured that this learning was fed back to front line staff and worked with them to devise practical ways to prevent reoccurrences.

Provider managers also ensured that lessons learnt that had implications for staff groups in other clinical areas, and any resulting changes to policies and procedures, were then shared more widely. Different providers had different ways of sharing these messages including briefings at team meetings, handovers, supervision sessions, learning sessions and newsletters.

The culture and reporting systems within organisations made an important difference to whether incidents were used to make positive changes. We found that staff used the system to good effect when it was easy to use, reviews took place promptly and staff could readily see the positive changes to the way people worked.

Staff in some providers did not know what constituted an incident or near miss or what to report. There was no shared definition and, if the same incident happened in two clinical areas, one staff group would report it and the other would not. In some services, staff told us that their reporting systems were

cumbersome and that the time and effort required to report put them off from doing so. Others told us that they did not receive a response or feedback about what action had been taken in a timely fashion and that this put them off using the system in the future.

In some providers we found examples of harm which could have been prevented if lessons had been learnt from previous incidents or near misses.

Same-sex accommodation

The Mental Health Act code of practice (last updated in 2015) sets out the requirements relating to gender segregation on mental health wards. In 2011 the Chief Nursing Officer and Deputy NHS Chief Executive asked providers to declare that they were compliant with the guidance. Gender segregation both protects patients from potential sexual abuse or harassment and helps maintain patients' dignity.

During our early inspections, we have found a number of wards that do not comply with the guidance on gender segregation. We found wards where no attempt has been made to locate bedrooms for men and for women in separate areas, where men or women have had to walk through the bedroom or bathroom areas of the opposite gender in order to reach communal areas and where there is no lounge area that can be used by men only or by women only.

In some cases, we have concluded that senior staff were not aware that wards were not compliant with the guidance.

We recognise the challenges many providers face in relation to the buildings in which some wards are located. However, we have usually found that, following our inspection, the provider has been able to make relatively simple adjustments that make wards compliant.

We have produced a brief guide on same sex accommodation which can be found on our webpage: www.cqc.org.uk/content/brief-guides-inspection-teams or directly **here**.

Ligature points

Many mental health wards are located in old buildings and/or are not purpose built to accommodate people who might be at risk of suicide. Even in purpose built wards, it would be difficult to remove all fixtures and fittings to which a ligature could be attached by a patient who intended to strangle themselves.

We found good examples where providers had used a ligature risk assessment tool. They used this as part of an ongoing programme to review the risks within their clinical environments. The results of this were used to draw up an action plan for how the risks could be minimised through both structural modifications and through good assessment of, and planning for, individual patients.

Some providers had not taken a structured approach to assessing ligature risks. Some used a tool that assessed general risks in the ward environment but that did not include specific identification of potential ligature points. In some cases, staff had identified ligature points in a room but had not taken steps to ensure that patients who were at risk did not have unsupervised access to that room. On other wards we found that, although staff had identified ligature risks in some bedrooms, they did not use individual risk assessments to ensure that these bedrooms were not allocated to patients at high risk of suicide.

We have produced a brief guide on ligature points which can be found on our webpage: www.cqc.org.uk/content/brief-guides-inspection-teams or directly **here**.