Mental Health Act 1983 monitoring visit

Provider:	Cygnet Health Care Limited
Nominated individual:	Michelle Jones
Region:	Central
Location name:	Cygnet Hospital Derby
Ward(s) visited:	Litchurch
Ward types(s):	Secure ward - Low
Type of visit:	Unannounced
Visit date:	21 January 2019
Visit reference:	40305
Date of issue:	06 February 2019
Date provider action statement to be returned to CQC:	26 February 2019

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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available upon request.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:

Litchurch ward is a 15-bedded male low secure ward for patients between the ages of 18 to 65. This ward is part of Cygnet Derby low secure hospital site. Patients admitted to this hospital have a severe and enduring mental health illness.

This ward has a regional catchment area, accepting patients from the Midlands area. Most patients are referred by NHS East Midlands. The average length of patient stay on this ward is 416 days, however some patients have remained on this ward for a longer period. Referrals to this ward are accepted from forensic wards (medium and low secure), prisons and psychiatric intensive care units.

On the day of our visit, 15 patients were admitted to the ward, all detained under the powers of the Mental Health Act (MHA). No patients were on overnight leave.

The hospital operates on two shift patterns: day and night. Planned staffing for all shifts matched actual staffing. The actual staffing for the day shift consisted of two qualified nurses and two health care assistants. Each day shift had an additional health care assistant/clinical administration assistant. The night shift comprised of two qualified nurses and two nursing assistants. The ward manager could increase staffing levels to manage increased patient need. Staff said shortfalls on the staff rota were covered by bank staff who receive an induction prior to working on the ward. Recently the ward used contracted agency staff who worked night shifts. The ward has a vacancy for one qualified nurse and one nursing assistant.

The multidisciplinary team consisted of a forensic consultant psychiatrist who was the responsible clinician (RC), speciality doctor, nursing staff including ward manager, occupational therapist and assistant, psychologist and assistant, social worker and social work assistant (both part time), substance misuse worker and access to community staff.

Patients have access to physical healthcare services. On admission, all patients are registered with a local GP practice. A GP from that practice visits the hospital every week and patients have the option of attending the GP practice. The hospital has a contract with an external pharmacy service who visits the hospital site every week.

Patients have access to facilities on and off the ward such as a garden/courtyard, activity and quiet rooms, laundry, communal bathrooms, dining room, and lounge/games rooms. Patients had access to a drinks area where they could make hot and cold drinks when they wanted to. Off the ward, patients have access to a gym, therapy kitchens, visitors room and multi-faith room.

How we completed this review:

This was an unannounced visit by a Mental Health Act reviewer (MHAR).

During the visit:

- We spoke with one patient in the presence of the ward manager.
- We spoke with three other patients in a group however due to their presentation, they were not consistent in their feedback about their care and treatment.
- We received one completed share your experience form.
- We reviewed the records of three detained patients.
- We spoke with the ward manager, advocate and nursing staff.
- We read the ward's most recent blanket restrictions audit.
- We completed a tour of the hospital with the ward manager.
- We gave feedback to the ward manager at the end of the visit.

What people told us:

We spoke with one patient and received one completed share your experience form. Patients said ward staff were kind, helpful and treated them with respect. The patient we spoke with was aware of their rights under MHA and appealed against their detention.

We spoke with three patients in a group, however due to their presentation, they were not consistent in their feedback about their care and treatment.

Past actions identified:

The last MHA monitoring visit was completed on 20 June 2016. The following issues have now been resolved:

- The status of a patient detained under section 38 of the MHA was not clear. There was no up to date information regarding the status of this section in the files.
- The information leaflet regarding section 38 was misleading.
- One T2 certificate authorised over the electronic British National Formulary limits. A high dose anti-psychotic monitoring form supported this, however the medication had changed since that form was completed. This meant the high dose monitoring form contained both the wrong medications and wrong total of combined medications.

Domain areas

Protecting patients' rights and autonomy:

Staff provided patients with information about their legal position and rights, as required under section 132 of the MHA. Written information relating to section 132 rights of the MHA was provided to all patients in accessible formats. Staff used a form to record that they had informed patients of their rights, this form indicated the frequency staff should remind patients of their rights and significant circumstances when patients should be reminded of their rights.

All patients we spoke with were aware of their rights under the MHA and their section 17 leave entitlements. We saw evidence of this in patients' files.

Patients had access to advocacy services. Advent Advocacy provided independent mental health and mental capacity advocacy within the hospital. Patients could self-refer or staff could make referrals on their behalf. We spoke with the advocate who visited the hospital twice weekly. They said ward staff had a good understanding of advocacy services and patients actively used the service. Information about advocacy services, how to make complaint to the provider, making a complaint to CQC about the provider and safeguarding were displayed on noticeboards in patient areas.

Most patients had access to their own mobile phones and could access the internet. Staff said depending on the outcome of a risk assessment most patients had their own smart mobile phone with internet access which they paid for themselves. We saw signed mobile phone agreements in all patient records we read. The ward had a telephone room for patients to make private telephone calls. This room contained a payphone and a separate telephone for patients to contact key professionals such as their solicitors and CQC. Dependent on restrictions placed by the Ministry of Justice and multi-agency public protection arrangements, some patients had supervised computer access. Patients had supported computer access in the hospital's recovery college.

Litchurch ward was based on the hospital's ground floor. All patient bedrooms were single rooms with en suite shower rooms. Patient bedrooms were based in two separate areas off the main lounge. Bedroom doors had observation windows which helped staff complete their observations. Patients had access to lockable cupboards in their bedrooms to store their valuables. All patients had keys to their bedrooms, we saw they freely accessed their rooms.

Staff and patients developed a patient search protocol linked to risk. Staff said patient searches were based on a traffic light system based on the use of illicit substances. Patients' searches were completed with the patient's consent using equipment such as an electronic wand and pat down. We observed patients were searched in private and all patient searches completed were logged in patients' records.

We read the ward's blanket restriction audit. The ward manager said this document was written by staff and patients documented all blanket restrictions on the ward and how these restrictions can be mitigated. This demonstrated evidence of patient involvement and regard for least restriction.

Smoking was not allowed on the hospital site. Patients were given support to stop smoking if they wanted to. Staff said patients were encouraged to smoke off the hospital site whilst on leave and patients were not permitted to smoke during therapeutic leave. We read a patient was prescribed medication to support them to stop smoking.

Assessment, transport and admission to hospital:

All admissions to this ward were planned. Detention paperwork was available on a paper record system kept in the hospital. This included the approved mental health professional reports and Ministry of Justice letters where applicable. All detention paperwork seen evidenced the need for the patients' detention.

Additional considerations for specific patients:

We did not review "additional considerations for specific patients".

Care, support and treatment in hospital:

Care plans were detailed, diverse and contained the patient's perspective. All patients' records contained various care plans such as social needs and restriction on freedom. We saw evidence of patients' goals, aspirations and opinions written in their care plans. Care plans were written in the patient's voice using language familiar to the patient and frequently reviewed with the patient and multidisciplinary team. Patients we spoke with said they participated in their care plan meeting and had copies of their care plans. We read on some care plans patients documented when they did not agree with its contents and refused to sign.

We looked at three risk assessments. They were fully completed and updated as required. We saw staff complete specialist risk assessments, for example, in all patient records, we saw staff completed the Historical Clinical Risk Management-20 version 3. Staff completed other specialist risk assessments such as Short Term Assessment of Risk and Treatability and Structured Assessment of Protective Factors for violence risk, an assessment to compliment the assessment of the risk of future violent behaviour or sexual violent behaviours in offenders and forensic psychiatric patients.

Mental capacity assessments we saw were detailed and decision specific. We looked at three mental capacity assessments relating to consent to treatment. These assessments contained detailed narrative of the assessment documenting the patient's ability to retain, weigh up, understand and communicate their decision. We observed capacity to consent to treatment on admission was reviewed at clearly

defined intervals which was mainly on a three-month basis.

All treatment was provided under an appropriate legal authority. Staff ensured the statutory treatment form was kept with the medication card. This ensured staff lawfully administered medication in line with the statutory forms. We read detailed discussions between the responsible clinician and the patient where the patient was treated under section 58 of the MHA and on the authority of a T2 form. A patient we spoke with could tell us about their prescribed medication, felt involved in discussions about their treatment and declined specific prescribed medication as they believed it was not appropriate for their treatment.

Staff offered to complete advanced statements with patients however all patient records we read showed patients declined to complete this document. Staff recorded this decision in patient records and frequently reviewed this decision with patients.

Patients had access to psychological therapies to enable them to manage their emotions and behaviours. For example, the ward's psychologists offered individual and group offender programmes for violence, sexual offences and offences using fire. Patients had access to the hospital's recovery college where they could complete courses on assertiveness, budgeting and social skills. These interventions were offered in groups or individually.

Staff measured patient rehabilitation outcomes every three months which were discussed with the patient and wider multidisciplinary team. Outcome measures are tools that document patient progress and engagement in the rehabilitation process. For example, for the first six weeks from patient admission, staff completed a Recovery Star with the patient which focussed on issues for example managing mental health, addictive behaviours and living skills. Staff said the rehabilitation process was adapted to meet the patient's abilities and needs following a review of these outcome measures. We saw evidence of this in all patient records we read.

The ward's speciality doctor was the clinical lead for physical health care.
Staff said patients did not experience any difficulty accessing GP care. Patient records we read showed evidence of patients receiving monthly and annual physical health checks.

The hospital's seclusion suite was based on Litchurch ward. We looked at the seclusion suite and observed patients from other wards could access this seclusion suite without entering Litchurch ward. We looked at the seclusion suite and noticed it was not designed in line with chapter 26 MHA Code of Practice as the seclusion room had blind spots. The observational window did not allow staff to have full sight of the patient when they were in the seclusion room. The ward manager said this suite was due to be fitted with closed circuit television to help staff observe patients whilst in the seclusion room. On the day of the visit, there were no patients from Litchurch ward nursed in the hospital's seclusion suite and no patients subject to long term segregation.

All staff received annual training in the prevention and management of violence and

aggression. Restraint was used as a last resort.

Leaving hospital:

All patient records we read showed patients had escorted leave. The responsible clinician used a standardised system to record section 17 leave and completed a risk assessment specific to leave. This included clear terms and conditions to support the patient's leave. In all patient files we read, staff completed a pre-and post-risk assessment for section 17 leave. The responsible clinician indicated in the patient records whether a copy of the leave form had been given to the patient.

In all patient records we saw a photograph of the patient and staff documented a description of the patient prior to them taking leave.

We saw Ministry of Justice correspondence relating to section 17 leave which included approval for escorted leave for medical appointments. Staff confirmed there were no significant delays seeking Ministry of Justice permission for section 17 leave.

We read evidence of discharge planning prior to patient discharge. Patients on Litchurch ward were referred to supportive accommodation, family home and to open rehabilitation wards. For example, we read care programme approach documentation which noted involvement with specialist external agencies such as mental health community teams and commissioners. We read where appropriate, patients would be discharged back to prison.

During our visit there were no patients absent without leave (AWOL).

Professional responsibilities:

We did not interview the MHA administrator who was based at the hospital site. Their duties included informing patients and nearest relatives of tribunals, organise Hospital Managers hearings and contacting second opinion appointed doctors. The MHA administrator was responsible for scrutinising detention paperwork when a patient was admitted to the ward to check accuracy of the paperwork. Copies of detention paperwork were kept in patient records and the originals kept in the MHA administrator's office.

In the records we saw, there was evidence of MHA scrutiny and systems appeared to be in place to alert the responsible clinician to expiration of sections.

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 - Action no. 1 **Care, support and treatment in hospital**	**MHA section:** **CoP Ref:** Chapter 26
We found:	
We looked at the seclusion suite and noticed it was not designed in line with chapter 26 MHA Code of Practice as the seclusion room had blind spots. The observational window did not permit staff to have full sight of the patient when they were in the room.	
Your action statement should address:	
How you will meet the guidance in the following paragraphs of the MHA Code of Practice: 26.109 The following factors should be taken into account in the design of rooms or areas where seclusion is to be carried out: • rooms should not have blind spots and alternate viewing panels should be available where required	

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

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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Audience	Providers
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