Mental Health Act 1983 monitoring visit

Provider:	University Hospitals Coventry and Warwickshire NHS Trust
Nominated Individual:	Mark Radford
Region:	North
Location name:	University Hospital
Location address:	Clifford Bridge Road, Walsgrave, Coventry, CV2 2DX
Ward(s) visited:	N/A
Ward type(s):	Other
Type of visit:	Announced
Visit date:	11 February 2013
Visit reference:	27103
Date of issue:	18 March 2013
Date Provider Action Statement to be returned to CQC:	17 April 2013

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 admission to discharge – whether patients have their treatment in the community under a supervised treatment order or are detained in hospital.

Mental Health Act Commissioners 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 However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 1998 and may be made available upon request.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	☒	Purpose, respect, participation and least restriction	☐	Purpose, respect, participation and least restriction
☐	Patients admitted from the community (civil powers)	☐	Admission to the ward	☐	Discharge from hospital, CTO conditions and info about rights
☐	Patients subject to criminal proceedings	☒	Tribunals and hearings	☐	Consent to treatment
☒	Patients detained when already in hospital	☒	Leave of absence	☐	Review, recall to hospital and discharge
☒	People detained using police powers	☒	Transfers		
		☒	Control and security		
		☐	Consent to treatment		
		☒	General Healthcare		

Findings and areas for your action statement

Overall findings

Introduction

We carried out an announced visit on 11 February 2013 to look at the use of the Mental Health Act at University Hospital. The Trust provides general secondary health care to people in Coventry and Warwickshire, and specialist services to the wider West Midlands area.

How we completed this review

We met with staff from the University Hospitals Coventry and Warwickshire NHS Trust. We also met with representatives from Warwickshire Police; West Mercia Ambulance and Coventry and Warwickshire Partnership NHS Trust who provide mental health services in this area.

University Hospital provided us with a range of documents prior to our visit. These included evidence of training delivered by the Arden Mental Health Project; records of multi-agency meetings and policies and procedures relevant to the care of patients with mental health issues.

We also visited the Emergency Department.

We looked at the patient records of three people. One had been detained under section 5(2) of the Mental Health Act. This had been lifted at the time of our visit. One patient had been assessed and another was awaiting assessment.

What people told us

We were not able to speak with any detained patients. The Trust were unable to identify anyone currentlly detained on the general wards. There were no detained patients in the Emergency Department.

Past actions identified

This is the first Mental Health Act monitoring visit to this provider.

Domain areas

Purpose, respect, participation and least restriction

The Trust needs to assure itself that staff understand and are actively applying the Guiding principles of the Mental Health Act, in particular that of 'Least restriction'.

Patients admitted from the community (civil powers)

Patients are not usually admitted to this hospital from the community under the powers of the Mental Health Act.

Patients subject to criminal proceedings

We were informed there were no patients subject to criminal proceedings detained under the Mental Health Act on the day of the visit.

Patients detained when already in hospital

Most patients who are detained whilst in the inpatient areas of Emergency Department, are held under section 5 of the Mental Health Act.

We have some concerns about the use of section 5 in the Emergency Department.

People detained using police powers

There is a clear written understanding that University Hospital is not a Place of Safety. The local Place of Safety is at the Caludon Centre on the same site. As University Hospitals Coventry and Warwickshire NHS Trust does not hold responsibility for the Place of Safety, we did not visit on this occasion.
If patients detained under section 136 of the Mental Health Act are in need of physical healthcare, or are intoxicated or under the influence of other substances, police bring them to the Emergency Department until they are well enough to undergo an assessment. Police remain with the detained person for the duration of their stay.

Police do not regard the Emergency Department as a public place, and are therefore unable to use their powers under section 136 in this area.

Partnership working and systems

We spoke with a representative from Warwickshire police force. He told us that the operational protocol between police and ambulance services was working well, and that communication between the two services had improved. He also said that the attendance of a representative from the Emergency Department at the section 136 multi-agency meeting had led to a better understanding of the responsibilities of partner agencies. There is a clear written understanding that University Hospital is not a Place of Safety.

We met with a representative from West Midlands Ambulance service. He told us about training in mental health issues available to ambulance crews. This is reinforced by a on-the-job mentoring service.

There is no service level agreement with the Coventry and Warwickshire Partnership NHS Trust. Representatives from the Partnership Trust believe that such an agreement would enable University Hospitals to draw on their mental health expertise in a number of areas, including the scrutiny of legal documentation. We heard evidence that the Partnership Trust provide appropriate support for detained patients accessing outpatient and inpatient services at the acute hospital.

Staff practice

All of the staff we met with showed a positive and respectful attitude towards mental health service users. Staff use an assessment tool to identify mental health needs, and ensure vulnerable patients are supported appropriately. The Mental Health Liaison Team are based in the Emergency Department and provide valuable support to patients with mental health issues, and medical staff involved in their care.

There was evidence of training provided for all staff in mental health issues, and the Mental Health Act. The Arden Mental Health Project has made an extremely positive contribution in this area. Staff working on older adults wards receive training in capacity issues. This has been successful, and may also be delivered to other staff.

However, we have concerns about whether all staff are putting this training into practice.

Patients experiences

We have some concerns about the patient experience of the Emergency Department because of the lack of privacy in interview areas.

Admission to the ward

Patients detained under the Mental Health Act are supported by a member of staff from Coventry and Warwickshire Partnership Trust whilst receiving healthcare at University Hospitals. They ensure the legal documentation and a summary of the care plans are available.

We are concerned that staff at University Hospital may have limited knowledge of some relevant aspects of the Mental Health Act. These include the authority under which staff administer medication to people detained under the Act.

Tribunals and hearings

We heard evidence that patients on the older adults wards at University Hospital have access to general advocacy and Independent Mental Capacity Act Advocates (IMHAs) as and when appropriate.

However, we are concerned that some detained and informal mental health patients may not be aware of their rights. This includes their right of detained patients to access the Independent Mental Health Advocate (IMHA) service.

Leave of absence

Staff are aware of the use of section 17 to authorise leave for detained patients receiving treatment at University Hospitals.

Transfers

There are some concerns about how long some patients have to wait to transfer to a bed on a mental health ward.

Control and security

We spoke with two security representatives. Security personnel are trained in conflict resolution and conflict management. They are shortly to receive training from a new provider, and are looking to undertake some training specifically in mental health issues.

There is clear guidance about when the presence of security personnel is necessary to support staff caring for patients in the Emergency Department with mental health issues.

We are unclear whether security personnal are trained in the use of anti lligature kits. This may be an issue due to the number of ligature points in the Emergency Department.

Consent to treatment

There are some concerns about the assessment and recording of capacity and consent. We have also identified that staff may have limited knowledge of the provisions of the Mental Health Act relating to capacity and consent.

General Healthcare

We noted that the Emergency Department has fixtures and fittings that could be used as ligature points.

Other areas

There are no other areas that gave cause for concern.

Section 120B of the Act allows for 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 1 Patients detained when already in hospital	**MHA section:** 5 **CoP Ref:** 2.2, 12.17

We found:

We looked at the medical records of patient A. There was an entry stating that doctors should use section 5(2) of the Mental Health Act if this patient tried to leave the hospital.

Paragraph 12.17 of the MHA Code of Practice states that although "Doctors and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave.... they may not leave instructions for their nominated deputy to use section 5."

Paragraph 2.2 of the MHA Code of Practice says that all patients should be told their rights in a "clear and unambiguous" way. Patient A's legal status is ambiguous and therefore they cannot be aware of their rights. This is unacceptable.

Patient A was effectively detained, and her liberty curtailed, possibly without her knowledge. This is not in keeping with the "least restriction" principle of the Mental Health Act Code of Practice which states that people using the Act must keep to the "minimum the restrictions they impose on the patient's liberty."

Your action statement should address:

Ensuring adherance with paragraph 12.17 of the MHA Code of Practice when considering the use of section 5.

Ensuring adherance with paragraph 2.2 of the MHA Code of Practice.

Ensuring adherance with 'Least restriction' principle of the MHA Code of Practice.

Domain 1 People detained using police powers	

We found:
Staff from the Emergency Department told us about a leaflet they made available to police officers outlining their responsibilities when accompanying patients. However, the representative from Warwickshire Police thought this leaflet was out of date. For example, he said it contained incorrect information about hospital addresses. This could result in delays for the patient being transferred.

Your action statement should address:

Whether Emergency Department staff and police are referring to the same leaflet.

If so, please establish whether the leaflet contains accurate and relevant information for police officers.

Domain 1 Partnership working	**CoP Ref:** Chapter 13

We found:

The Trust does not have robust systems in place to record information about patients who are detained under the Mental Health Act. This made it difficult to carry out our duties as Mental Health Act Commissioners as staff could not identify whether there were any detained patients on wards in the hospital. Similarly, there is no system in place to scrutinise legal documents relating to detained patients.

Paragraph 13.12 of the Mental Health Act Code of Practice states that documents "should be scrutinised for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention." It goes on to say that "medical recommendations should also be scrutinised by someone with appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions stated in them". Hospital managers are responsible for delegating this duty.

Staff were aware that better monitoring systems are necessary to ensure that they are respecting the rights of detained patients.

There is no service level agreement with Coventry and Warwickshire Partnership NHS Trust. We met with representatives of C&WPNHST, who felt that a formal service level agreement would enable the acute Trust to make better use of their expertise in mental health, including systems for scrutinising documents.

Your action statement should address:

Ensuring adherance with Chapter 13 of the Mental Health Act Code of Practice.

Domain 1 Staff practice	**MHA section:** 5.58 & 132 **CoP Ref:** 1; 2; 4; 5; 12; 20; & 23

We found:

The Trust provides training in mental health issues in the mandatory staff induction programme. We also saw evidence of training relating to the Mental Health Act and the Mental Capacity Act. It was unclear as to what systems are in place to monitor whether staff are putting this training into practice.

We looked at the records of three patients. One had been detained under section 5; one had been assessed but not detained and one was awaiting assessment. These records showed some confusion about the use of section 5, patient rights under section 132 and variable consideration of capacity and consent as covered by section 58.

We do not expect staff in an acute general hospital to have detailed knowledge of the Mental Health Act as the vast majority of their patients will not be detained under the Act. However, a basic understanding of the guiding principles; detention, including holding powers; patient rights and the assessment of capacity and consent would be desirable. We direct you to chapters 1;2; 4; 5; 12; 20 and 23 of the Mental Health Act Code of Practice.

Your action statement should address:

Ensuring adherance with chapters 1;2; 4; 5; 12; 20 and 23 of the Mental Health Act Code of Practice.

Domain 1 Patient experiences	**CoP Ref:** Chapter 16

We found:

The Mental Health Liaison Team interview patients with mental health issues in the Emergency Department. This interview may take place in a room with a very large glass window. Although this may improve staff safety in the absence of a panic alarm, it does not meet the patients needs for privacy and dignity.

If this room is occupied, interviews may take place in a curtained cubicle in a four bed room on the observation ward. This means that patients may have to risk discussing confidential matters where they may be overheard.

Paragraph 16.2 of the Mental Health Act Code of Practice states that "hospital staff should make conscious efforts to respect the privacy of patients while maintaining safety".

We understand that plans are in hand to make changes to the physical environment of the Emergency Department. Originally, these changes included a purpose built room to carry out assessments of mentally unwell patients. We were told this is not now the case. Such a room would improve the experience of mental health service users in the department.

People in mental distress should not have to discuss their health issues where they can be seen or heard by other staff or patients. Interviews should take place in a private room. If there are concerns for the safety of staff, other measures should be put in place to address these.

Your action statement should address:

Ensuring adherance with paragraph 16.2 of the Mental Health Act Code of Practice.

Addressing issues of staff safety.

Domain 2 Admission to the ward	**MHA section:** 58 **CoP Ref:** Chapter 23

We found:

Coventry and Warwickshire Partnership NHS Trust provide support to detained patients receiving physical healthcare as both outpatients or when admitted to a ward. They ensure that legal documentation is available and also provide a summary of care plans.

However, staff at University Hospital seemed unclear about the legal documentation. In particular, they showed limited knowledge of the authorisation necessary to administer medication to a detained patient under section 58 of the Mental Health Act. Chapter 23 of the Mental Health Act Code of Practice covers these issues. This could result in staff administering mental health medications without the proper authorisation. This could constitute an assault on the patient.

Your action statement should address:

Ensuring adherance with Chapter 23 of the Mental Health Act Code of Practice.

Domain 2 Transfers	**CoP Ref:** Chapter 11.7

We found:

There was evidence that a patient can wait some time to be transferred to a mental health ward. For example, patient A had been waiting for transfer for at least 24 hours. We heard that one patient had been waiting 3 days. This may be beyond the control of the University Hospitals Coventry and Warwickshire NHS Trust because no bed is available on a mental health ward.

We heard there may also be delays in carrying out MHA assessments. We are not sure whether this is because section 12 doctors or Approved Mental Health Professionals (AMHPs) are not immediately available. We would like further information about delays in carrying out assessments because doctors or AMHPs are not available.

We also heard from the representative of the ambulance service that transfers can be delayed at times because of the pressures on the Emergency Department and ambulance service.

Paragraph 11.7 of the Mental Health Act Code of Practice states that the transfer of patients will take place in a "timely manner".

Your action statement should address:

Ensuring adherence with paragraph 11.7 of the Mental Health Act Code of Practice. in liaison with the local ambulance service.

Providing further information about delays in carrying out MHA assessments.

How you will address and monitor with the Coventry and Warwickshire Partnership NHS Trust the timeliness of transfers .

Domain 2 Control and security	**CoP Ref:** Chapter 15

We found:

Security personnel undergo training in conflict resolution and conflict management. There are clear guidelines on when they will be involved in monitoring patients with mental health issues. However they do not currently receive specific training in mental health awareness. We were informed this omission will be addressed in the near future.

Chapter 15 of the Mental Health Act Code of Practice provides guidance on how to respond to violent and disturbed behaviour in relation to mental health service users, whether detained or informal. University Hospitals Coventry and Warwickshire NHS Trust needs to consider whether it is meeting the guidance in this chapter.

Your action statement should address:

Ensuring adherance with Chapter 15 of the Mental Health Act Code of Practice.

Domain 2 Consent to treatment	

We found:

We looked at the notes relating to informal patient B. This patient has an unconfirmed diagnosis of dementia. The notes record this, and show he is awaiting a further assessment of his mental state. Recording of his capacity was inconsistent. It was considered in his notes, but not mentioned in the assessment tool which was not fully complete. The same was true of a safeguarding referral.

He appears to have received treatment under an appropriate authority.

Your action statement should address:

Consistent recording that capacity has been considered

Domain 2 General Healthcare	

We found:

There are numerous ligature points throughout the Emergency Department, including the curtain rails around the beds. This poses a risk to suicidal patients.

The Emergency Department makes use of a robust mental health triage tool. We understand that when staff identify patients as high risk, they are not left unattended. However, the person in attendance may well be a member of the security team or other staff members with limited or no training in mental health. This raises questions. Are staff trained in the necessary response to someone who is attempting to hang themselves? Are anti ligature kits available in the department?

Paragraphs 2.26 - 2.28 of 'Preventing suicide in England: A cross-government outcomes strategy to save lives' directs health care providers to toolkits that may support them in considering the risks posed to suicidal patients in the general hospital environment.

Your action statement should address:

Considering how best to manage risk to suicidal patients within the Emergency department.

Staff training in the prevention of suicide as per national suicide policies.

Information for the reader

Document purpose	Mental Health Act monitoring visit report
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