Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

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Foreword

I am pleased to introduce the fourth annual report of Healthcare Inspectorate Wales' (HIW) work in monitoring the use of the Mental Health Act across Wales in 2013-14. This is the fifth year that HIW has been responsible for monitoring the Mental Health Act in Wales.

The Mental Health Act (1983) and the accompanying Code of Practice were introduced to protect individuals who become vulnerable due to their mental health. The Act is designed to ensure that any decision to compulsorily admit an individual to hospital, therefore depriving them of their liberty, is justified and in the best interests of that individual. The Act allows for medical treatment to be administered to individuals who may not consent to it or have the capacity to consent to it. This is a unique area of healthcare as individuals can be legally detained and treated in hospital. It is therefore crucial that the powers that individuals are subject to are appropriately monitored.

We undertake monitoring of the application of the Act to ensure that those individuals detained under its powers are protected, safeguarded, supported and empowered as far as possible to make decisions over their care and treatment. It is also very important to review how organisations are discharging their powers under the Act and that they are appropriate, proportionate and in line with the law.

This report sets out our findings from the monitoring work undertaken by our Reviewers and Second Opinion Appointed Doctors during 2013-14.

We hope that the information in this report is helpful to those responsible for implementing the provisions of the Act and can be used to assist in driving improvement in Mental Health services. We also hope this report will be beneficial to individuals and their families who are subject to detention under the powers of the Act.

Dr Kate Chamberlain

Chief Executive

Healthcare Inspectorate Wales

Chapter 1: The Mental Health Act and our Role in Monitoring its Use

The role and purpose of the Mental Health Act

Mental Health services in Wales are predominately accessed by people who receive care and treatment voluntarily. This group of people are often referred to as informal patients. The rights of informal patients are the same as patients who have a medical or physical problem. There are instances where an individual may experience a period of severe mental illness and it is required that they are detained for assessment, care and treatment against their will. Patients who are detained under the Mental Health Act 1983 (the Act) are referred to as formal patients.

The core purpose of the Act is to keep patients safe and to ensure they are cared for in an environment conducive to support their recovery. The Act provides a legal framework to allow for compulsory care and treatment to be given, where appropriate, to an individual with a mental disorder who is in need of such compulsory treatment.

The Act allows for formal patients to be detained in a hospital environment or in the community, subject to certain conditions, as part of a Community Treatment Order (CTO).

The Act allows for individuals to be given treatment to which they have not consented to or in instances where an individual does not have the capacity to consent.

Some people can remain under the powers of the Act for considerable periods of time.

The Act provides numerous powers and responsibilities on a range of organisations and individuals, including:

- officers and staff of health boards, independent hospitals and social services departments, whether or not they work in mental health services
- police officers
- courts
- advocates
- Welsh Ministers

- the relatives of individuals who may be subject to the Act.

The Act is used in many environments, such as:

- hospitals
- mental health wards
- general medical wards for patients of all ages
- accident and emergency departments
- nursing homes
- patients' homes
- courts
- public places.

The Act places restrictions on the human rights of those individuals who are subject to its powers and can have serious consequences for them. The Act is clear in the processes that must be adhered to when an individual is considered for detention, and the processes that must be adhered to when an individual has been detained. The Act, and the Code of Practice for Wales, provide safeguards that intend to ensure individuals are not inappropriately detained or treated without their consent.

How the use of the Mental Health Act is monitored in Wales

The duty to ensure that the Act is lawfully administered in Wales is placed on Welsh Ministers. Welsh Ministers are required to monitor how services discharge their powers and duties in relation to patients detained under the Act who may be in hospital, subject to CTOs or guardianship. Welsh Ministers are specifically required to:

- keep under review the exercise of the powers of the Act in relation to detained patients and those liable to be detained
- investigate complaints relating to the application of the Act
- produce an annual report; and
- provide a registered medical practitioner to authorise and review proposed treatment in certain circumstances.

Since April 2009 HIW has undertaken the monitoring of the Act on behalf of Welsh Ministers. In order to achieve these responsibilities HIW established the Review Service for Mental Health (RSMH). The responsibilities of the RSMH is as follows:

- visiting detained patients in hospital settings
- reviewing the care and treatment provided to detained patients providing a Second Opinion Appointed Doctor (SOAD) service which appoints an independent registered medical practitioner to review, and where appropriate, authorise the proposed treatment plan of detained patients who either refuse to consent to treatment or are incapable of giving such consent. This service is provided to safeguard patients who do not consent to treatment.

The primary role of the RSMH is to ensure that anyone receiving care and treatment under the Act in Wales is treated with dignity and respect, receives appropriate and lawful treatment and is enabled to lead as fulfilled a life as possible.

Mental Health Act Reviewers

In order to achieve the focus of the RSMH, HIW utilises the expertise of Mental Health Act Reviewers (Reviewers). Our Reviewers visit and talk to individuals who are subject to the powers of the Act in psychiatric wards across Wales. Our Reviewers assess the environment, talk with staff members and review the statutory documentation of detained patients to establish whether the requirements of the Act and Code of Practice have been satisfied. Reviewers also consider issues such as privacy and dignity, food and nutrition, access to general healthcare services and care and treatment planning.

Our reviewers visit a number of settings each year, both in the NHS and Independent sector, as part of a rolling inspection programme. The vast majority of our visits are unannounced. Organisations visited will receive verbal feedback at the end of the visit from the Reviewer, a management letter detailing our findings and if appropriate an urgent actions letter if significant issues were found.

Second Opinion Appointed Doctor Service (SOAD)

Welsh Ministers are responsible for fulfilling the requirement of the Act to appoint a registered medical practitioner to authorise treatment of detained patients under certain circumstances. HIW have been delegated this function since April 2009 and use a pool of medical practitioners known as Second Opinion Appointed Doctors (SOADs).

SOADs are responsible for safeguarding the rights of individuals who are detained under the Act who either refuse, or are considered incapable, to consent to treatment. SOADs do not provide a second clinical opinion about a patient's condition or diagnosis. Instead they decide whether the rights and views of the individual have been fully taken into account by clinicians and whether the proposed treatment is in line with guidelines and is appropriate to that individual.

SOADs are required to consider treatment plans for:

- detained patients of any age who have capacity to consent to medical treatment and have refused to give their consent
- detained patients of any age who lack the capacity to consent to medical treatment
- detained patients over 18 years of age who lack the capacity to consent to electroconvulsive therapy (ECT)
- informal or detained patients under 18 years of age whom ECT is proposed, whether the patient is consenting or lacking capacity to consent
- detained patients on CTOs who lack the capacity to consent to proposed treatment (patients with the capacity to consent now have their CTO authorised by their Responsible Clinician)
- formal and informal patients who are being considered for very serious and invasive treatments, such as psychosurgery.

When the SOAD has reviewed the treatment to be prescribed, and is satisfied the patients views and rights have been taken into account, he/she will issue a statutory certificate which provides legal authority for treatment to be given. SOADs can deviate from the proposed treatment plan if they consider it necessary. For example a SOAD may only authorise part of the proposed treatment, place conditions or time limits on treatment, set a maximum dose level of medication or place a limit on the number of courses of ECT to be given.

Investigation of complaints

There is a duty placed on Welsh Ministers by the Act to make arrangements for the investigation of complaints that relate to the exercise and discharge of powers under the Act.

In 2013/14 HIW received a number of contacts by letter, email or telephone raising concerns with us. The majority of the concerns received related to:

- detained patients challenging the decision to be detained
- section 17 leave issues
- problems with access to physical healthcare
- transfers between hospitals
- attitude of staff
- privacy, dignity and cleanliness issues.

Many of the issues that were raised to HIW fell outside our remit and the powers delegated to us. For example, we received complaints in relation to challenging the decision not to grant section 17 leave, to be released from detention, to be moved hospitals or wards and to have medication changed. In these instances we provide the complainant with the options available to them and how to raise their complaint with the organisation concerned in an attempt for the issue to be resolved locally. We also signposted individuals to other organisations who can assist with such matters, for example advocacy services and the Mental Health Review Tribunal.

Even though not all of the complaints we receive can be investigated by us, we make use of all intelligence received. We maintain an organisational record for all services in Wales and when complaints are received we log this information and the issues that were brought to our attention. Such information is important and assists in the development of our annual inspection programme.

Annual Reporting

Each year we are required to produce an annual report that gives account of the work that has been undertaken to meet our responsibilities under the Act.

This is our fourth annual report in which we provide an overview of key figures and the findings of our work during 2013/14.

Chapter 2: Facts, Figures and Trends

In our previous annual reports we have analysed the number of admissions to Mental Health facilities in the reporting year. This includes analysing the number of detentions under the Act and also the number of individuals who access services on a voluntary basis.

The data relating to the number of admissions is collected and published by Welsh Government annually. Unfortunately the data for 2013-14 was not available for inclusion in this report. Welsh Government identified an error in the data submitted for admissions of patients to mental health facilities in Wales. As this affects the Wales level estimates of admissions, the release was withdrawn while the correct data was obtained.

The table below shows the number of admissions to Mental Health facilities in Wales until the end of March 2013.

Table 1: Number of inpatient admissions to mental health facilities

	All admissions to mental health facilities	Admissions under the Mental Health Act 1983	Percentage of admissions that were under made the Mental Health Act 1983
2006-2007	11,017	1,310	11.9%
2007-2008	10,854	1,467	13.5%
2008-2009	11,101	1,673	15.1%
2009–2010	11,356	1,452	12.8%
2010–2011	11,198	1,717	15.3%
2011-2012	10,773	1,428	13.3%
2012-2013	10,523	1,453	13.8%

The table above shows that each year there are over 10,000 admissions to mental health facilities in Wales and that on average over 12% of the population are detained under the Act.

Chapter 3: Detained Patients and Consent to Treatment

In Wales during 2013/14:

- **There were 690 requests for a visit by a Second Opinion Appointed Doctor (SOAD)**
- **595 SOAD requests related to the certification of medication**
- **65 SOAD requests related to the certification of ECT**

Any individual detained under the Act may be given treatment and medication with or without their consent for a period of up to three months. After this period a SOAD may be required to consider the proposed treatment plan.

The role of the SOAD

When a patient is willing and has the capacity to consent, either the patient's approved clinician or a SOAD can certify consent and authorise the proposed treatment. If a patient lacks the capacity to consent or refuses to consent, the proposed treatment plan can only be authorised following certification by a SOAD. This measure is in place to ensure patients are safeguarded.

As detailed in chapter one, SOADs are required to consider treatment plans for patients detained under the Act in a variety of circumstances. These relate to their consent status and/or their capacity to consent to proposed treatment.

SOADs will only certify treatment after he/she visits the patient and discusses the case with the Approved Clinician and two other statutory consultees. Statutory consultees are professionals who have been involved in the care or treatment of the patient, such as nurses and social workers. The decision to certify treatment, either full, in part, or not at all, is only taken when all necessary information has been reviewed and evaluated by the SOAD. When certifying treatment the SOAD will clearly specify the maximum dosage of medication, the route of administration and any time limits on the duration treatment can be given.

SOADs play an important role in safeguarding individuals who are subject to detention under the Act and promoting their human rights. SOADs are key to ensuring proposed treatment is ethical and appropriate.

HIW are responsible for operating the SOAD service. Although we facilitate and appoint SOADs to requests, we have no influence over the outcome of the SOADs judgement and their opinion is completely independent. This is a further safeguard to the patient to ensure their treatment, and the appropriateness of it, is considered.

In 2013-14 HIW appointed a new Lead SOAD who provides leadership to the pool of SOADs. The new lead SOAD will focus on recruitment of additional SOADs to the pool available, provide support and guidance to current SOADs and also look at developing HIWs processes and procedures in relation to the SOAD service.

Requests for SOAD visits received during 2013-14

Table 2 shows that the number of requests made to HIW for a SOAD in 2013-14 decreased. This is a trend that has continued since 2011-12. This decreasing trend is largely explained by changes whereby SOADs are no longer required to authorise CTOs where the patient has the capacity to consent to treatment. The patient's Responsible Clinician can now fulfil this function and authorise the CTO on a Form CO8.

Table 2: SOAD requests for certification by type of request

	Medication	ECT	Both	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690

SOADs play a crucial role in ensuring that the treatment individuals detained under the Act are prescribed is appropriate and ethical. We have set ourselves very tight timescales for the visits. Once a request is received by HIW for a SOAD, we aim to ensure that it takes place within:

- two working days for a ECT request
- five working days for an inpatient medication request
- 10 working days for a CTO request.

In our previous annual reports we have described experiencing some difficulty meeting these timescales. Many of our SOADs have reported difficulties in undertaking requests and this can impact on the timeliness of visits and their completion. The difficulties SOADs have reported to us are as follows:

- **Patients unavailable at the time a SOAD assessment was due to take place:** there have been a number of requests where a SOAD will make arrangements to see a patient to review the proposed treatment and the patient is not available when the SOAD visits. For inpatients this can be due to section 17 leave being accessed or the patient transferring to a different ward or hospital and HIW not being informed. For patients on Community Treatment Orders (CTOs) there have been a number of requests where a patient has failed to attend the scheduled SOAD appointment. CTOs have historically presented problems to SOADs, as patients are to be seen in the community and these visits are difficult to facilitate.

- **Responsible Clinicians not available:** SOADs need to discuss the proposed treatment with the patient's Responsible Clinician before it can be legally authorised. There have been a number of occasions when the Responsible Clinician is not available to discuss the case with the SOAD and this has caused delays. There have been delays in SOADs issuing certificates to authorise treatment as they were unable to contact the Responsible clinician as a result of them being unavailable due to annual or sick leave. It is expected that arrangements are made so that another Responsible Clinician is put in place to cover any absence of a Responsible Clinician. This helps to avoid any unnecessary delays to issuing statutory certificates when treatment is authorised by a SOAD.

- **Statutory Consultees not available:** SOADs need to discuss the proposed treatment with two professionals who have been involved with the patient's care. Several visits have either been delayed or cancelled as nominated consultees were not available. The organisations that have submitted the request have a responsibility to ensure two consultees who have been professionally involved with the patient are available to have a discussion with the SOAD. There have also been instances where the consultees nominated are not aware they have been put forward and sometimes have not had enough professional involvement with the patient to have an informed view about the proposed treatment. Organisations that

submit a request for a SOAD need to ensure the nominated consultees are aware they have been put forward and have had enough involvement with the patient to have a view about proposed treatment.

- **Patient notes and clinical records not available**: SOADs have informed HIW they can often have difficulty locating the notes and clinical records of patients who a request has been made for. This has led to delays in the SOAD completing a request.

The Code of Practice states that organisations hold responsibility for making sure arrangements are in place to facilitate a SOAD visit.

Chapter 4: Patient Experience

Individuals who are detained under the Act are very unwell and due to their illness can be profoundly vulnerable. Detention under the Act can be a difficult experience for them and their family. In view of this our Reviewers provide a safeguard to detained patients, visiting settings where patients are liable to be detained under the Act. The purpose of these visits is to review whether the Act is being applied appropriately in line with legislation and that the rights and views of patients are respected. Reviewers also measure the settings visited against the Code of Practice to ascertain if services are focused on promoting recovery, protecting them and others from harm and keeping restrictions to a minimum.

In 2013-14 we undertook 55 visits to settings where patients are liable to be detained across Wales. The organisation visited is provided with feedback at the end of the visit. This feedback is then followed by a management letter which is sent to the Chief Executive or Responsible Manager. If our Reviewers find any issues that are of immediate concern then an urgent action letter will be sent to the organisation to seek assurances that the concern will be remedied in an appropriate timeframe.

Our visits focused on ensuring that any individual who is subject to detention under the Act is;

- treated fairly, with dignity and respect
- made aware of their rights
- cared for in a suitable and appropriate environment
- given care and treatment with respect of relevant guidelines
- involved in their care and treatment planning as far as possible

As part of our visits our Reviewers:

examine and scrutinise legal documentation, care and treatment plans and risk assessments to form a judgement about compliance with the requirements of the Act

- meet and interview patients
- interview staff to test their knowledge and attitudes and how organisations are operating (issues such as staff training, supervision/appraisal and staff knowledge are explored)

- assess the environment where patients are cared for to ascertain that it is appropriate, clean and offers the individual patients privacy and dignity
- review policies and procedures to ensure the powers of the Act are discharged and delegated appropriately.

The remainder of this chapter provides a summary of the findings from our visits. The key themes are summarised under the headings which are the key questions that our Reviewers look to test during each of our visits.

Have the correct legal processes been followed?

Our Reviewers observed that the correct legal processes and scrutiny of statutory documentation had been followed in the majority of our visits.

We found from our reviews of detention documentation that at least one of the doctors completing recommendations for detention knew the patient and the other was Section 12 approved[1]. There were clear reasons given for the detention of patients and why detention under the Act was the most appropriate way of providing care. The Approved Mental Health Professional (AMHP)[2] reports were available in the patient notes and the AMHP had identified and contacted the patient's Nearest Relative.

Are adequate records kept?

We raised a number of issues to organisations about the quality of record keeping and management of records.

We found in a number of organisations disparity between the legal documentation available on the ward and the information held centrally by Mental Health Act Administration teams. This could make it difficult for ward based staff to have an accurate perception of a patient's legal status. This is of concern as staff require the most up to date information to ensure that they are treating patients legally under the Act and upholding their rights.

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[1] A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder.

[2] A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.

Our Reviewers noted in a number of organisations that records were disorganised and locating some information was challenging.

We found in several organisations visited that patients had several volumes of notes on the ward and that Mental Health Act documentation was spread across different volumes. This again makes it difficult for ward staff to ensure all the documentation relating to the Act is available and correct. Mental Health Act documentation should be maintained in the patient's current volume of notes.

In all instances where we found adequate records were not maintained we have requested the organisation concerned undertake audits of detention documentation to review compliance with statutory duties in respect of the Act and Code of Practice.

Where appropriate has consent been obtained and the assessments of capacity undertaken?

As outlined in chapter three, the Act sets out clear procedures in relation to the authorisation and administration of treatment. It is made clear a patients' Responsible Clinician must attempt to gain consent from a patient before the commencement of proposed treatment. Patients can be treated without consent during the first three months of their admission, however, clinicians should make every effort to obtain consent from individual patients. As set out in the Code paragraph 17.26;

> *"Even though the Act allows treatment to be given without consent during the first three months, the clinician in charge of the treatment should ensure that the patient's valid consent is sought before any medication is administered. The patient's consent or refusal should be recorded in the case notes…"*

Principle one of the Mental Capacity Act (2005) is clear that every adult has the right to make their own decisions and must be assumed to have capacity unless it is proved otherwise. It cannot therefore be assumed an individual does not have the capacity to consent to treatment just because they have a mental disorder and are detained under the Act.

During our visits the overall quality of records held about the assessment of an individual's capacity to consent to treatment was variable between the organisations visited. It was often the case that the records concerning capacity lacked sufficient detail. In many cases it could not be evidenced that attempts had been made to obtain consent from patients at the first administration of treatment. Responsible Clinicians should make clear entries into patient's

records to document any discussions held about proposed treatment and the views of the patient about it.

During our visits we did find good examples of how consent and assessments of capacity had been followed:

The Experience of Patient A

The "three month rule" had been complied with regarding the assessment of their capacity to consent and whether they had consented.

The Responsible Clinician at the time of this assessment made detailed notes of patient A's capacity and whether they were freely consenting. This practice is advised in the Code of Practice for Wales (17.28). It was pleasing to see that it had been done with such detail and consideration. As a result of this assessment a CO2 certificate of treatment was issued. When the treatment plan changed a month later, similar detailed entries with regard to capacity and consent were found in the notes from the Responsible Clinician at that time. This allowed for a different CO2 certificate of treatment to be issued. Three days after this certificate was issued, the Responsible Clinician noted that the patient had withdrawn their consent for part of their treatment plan. Immediately, a request was made to HIW for a Second Opinion Appointed Doctor (SOAD) to visit. This visit took place and the patient was receiving their treatment under the authority of a CO3 issued by the SOAD. The actions and practice of this Responsible Clinician are exactly what the Act and the Code of Practice require.

Are individuals detained under the Act aware of their rights under Section 132 of the Act?

Section 132 and 132A of the Act are clear that patients should be made aware of their rights in relation to their detention. Patients should also be made aware of details about their detention, any restrictions, renewal and discharge, information about consent to treatment and accessing independent mental health advocates (IMHAs). Paragraph 22.30 of the Code of Practice for Wales states; *Patients should regularly be given an explanation of their rights and restrictions.*

When we visit an organisation we always test this with the patients we interview to establish if they understand the implications of their detention and if they have been made aware of their rights under the Act. We also review their clinical notes to see if there is evidence that their rights have been explained to them, or that attempts have been made to do so.

The experience of patient B

We scrutinised patient B's legal detention documents and found there was generally good compliance with the Act. However, there was no evidence in patient B's records of their rights being explained to them under Section 132. We escalated this to the organisation and referred them to the guidance set out in the Code of Practice for Wales, paragraphs 22.29 – 22.31

In most organisations visited we found patients had been informed of their rights at regular intervals and this was documented within their notes.

We did however find instances where patients were not aware of their rights under the Act and it could not be evidenced from reviewing their notes that these discussions and presentation of rights had taken place.

Do individuals have access to an independent mental health advocate?

Independent Mental Health Advocates (IMHAs) are part of advocacy services that were introduced when changes were made to the Act in 2008. IMHAs provide independent support to patients subject to the Act to ensure they understand their rights and are able to express their opinions and concerns. IMHAs can help patients and their families understand their rights under the Act, attend meetings with patients and attend Mental Health Review Tribunals. Patients we spoke with during our visits expressed the benefit of engaging with IMHAs and the high level of support they had received.

In almost every organisation we visited there was information and posters on display to inform patients about how to engage with their local advocacy service. Patients we spoke with were aware of advocates and how to access them.

Since the introduction of Part 4 of the Mental Health (Wales) Measure 2010, the promotion and awareness of advocacy services has risen significantly on the wards we visit. Part 4 of the Measure extends the provision of an IMHA to all patients in hospital with a mental disorder in Wales, regardless of whether they are detained under the Act.

Is the environment of care appropriate and conducive to recovery?

Individuals detained under the Act can spend significant periods of time in an inpatient setting and in some circumstances they are unable to leave the ward due to the severity of their illness. For this reason it is crucial when we visit organisations that the appropriateness of the environment of care is assessed. The environment in which a patient is detained can have a major influence on the mood and recovery of an individual

Our Reviewers reported in most cases the organisations we visited had appropriate environments of care and efforts had been made so settings were clean, safe and therapeutic.

However, we found issues in some settings we visited in relation to their decorative state. The most common issues we found, and raised with the organisations visited included; poor standard of cleanliness, patient furniture in poor condition, carpets and floors stained and showing signs of wear and tear and strong and unpleasant odours.

In a number of our visits our Reviewers reported that garden areas were in need of maintenance and were not always accessible by patients due to the poor condition they were in.

Our Reviewers also described finding some organisations where seating in lounge and communal areas was arranged in an institutional style configuration. This is when seating is positioned around the walls. We encourage all organisations to make wards as homely and therapeutic as possible and even minor issues such as the position of seating can impact on the mood and recovery of patients.

Is the environment of care safe?

During our visits we observed a number of ligature points on wards. Generally the staff we discussed these with were aware of the risks of such ligature points and had plans in place to manage the risk. In most cases the ward utilised ligature risk assessments and individual risk assessments. In some organisations visited certain areas of the ward could not be used by patients, unless supervised by a staff member, due to the presence of ligature points.

While this is good management of the risk, in such cases we have recommended the organisations remove the ligature points so accessing certain areas of wards is easier for patients.

Not all of the organisations we visited had nurse call systems in place in patients' individual bedrooms. These systems are used to call for a member of staff if there is a situation where the patient needs assistance from a staff member.

We observed a lack of security alarms for staff and visitors in a number of settings we visited.

Are patients afforded privacy and dignity?

Individuals detained under the Act have had their liberty taken away from them and are compelled to reside in environments they would otherwise not necessarily choose. This makes it important for us during our visits to assess that patients are given privacy, as appropriate, and are treated with dignity. We found most of the organisations we visited do their utmost to protect the privacy and dignity of patients. However, due to a variety of reasons we still found some issues in relation to privacy and dignity.

The experience of patients at Ward A

En-suite toilet doors in patient's bedrooms had been removed and replaced with curtains. Many patients told us that they find this situation uncomfortable, embarrassing and undignified. While we understand the need to maintain patients' safety and reduce risks, we feel that the risk has to be balanced with patients' privacy and dignity and promotion of independence. We do not feel the organisation was assessing patient risk on an individual basis and had adopted a blanket approach to the ligature risk that may be posed to some patients by en-suite doors.

We recommended that the organisation ensure that appropriate, ligature-free doors are fitted to the entrance on the en-suite facilities that will maintain patients' safety but also their privacy and dignity

We found some issues with the vision panels on individual patient's bedroom doors. Vision panels within bedroom doors are used by staff to undertake observations on patients without disturbing them and entering their bedroom, however, as they offer a view into the patients bedroom it is crucial these are managed appropriately.

The experience of patients on ward B

Bedroom doors had viewing panels so that staff could undertake observations; however these did not require a specialist key and so they could be opened by non-staff. In addition patients were unable to operate the vision panel from inside their rooms if they had been left open. This was a significant issue in terms of privacy and dignity particularly since the patient group being cared for on ward B were mixed gender.

We immediately escalated this concern to the organisation to seek action and remedy of this situation

We again found issues in relation to privacy measures on windows that are overlooked by public areas and nearby housing. Where we found such issues we raised these with the organisation as this could clearly impact on the privacy and dignity of patients who are within the ward.

We observed on some wards we visited that there was sensitive and confidential patient information displayed on white boards in ward office areas. This was visible to patients and visitors to the ward. Where this was found it was raised with the ward staff on the day of the visit. This is concerning as this practice infringes on a patient's right to confidentiality.

Are bathroom and toilet facilities adequate?

We assessed the standard of bathroom and toilet facilities on all wards that we visited. There is still variation in the provision of bathroom and toilet facilities available on wards; some offer en-suite facilities while others have shared bathroom and toilets.

Most of the bathrooms and toilets we saw were appropriate for patients. However, we did observe some issues that needed to be raised with the organisation.

Common issues our Reviewers reported related to general maintenance issues such as taps not working or issues with the temperature of showers and baths. Generally, we found these issues had been escalated for repair within the

organisation, although some ward staff reported experiencing delays in the timeliness of repairs being undertaken.

We also found some facilities that were not suitable for the client group and required adaptations to be made such as hoists and handrails. This is an issue for patients who may have mobility issues and therefore experience some difficulty or require assistance when using the facilities.

Do patients have access to phones and rooms for private conversations?

Many patients we spoke with during visits expressed concern over access to phones or rooms to have private conversations with family and friends.

In a number of our visits we found pay phones for use by patients were situated in communal areas of the ward. Patients expressed their concerns to us in relation to background noise when making phone calls being disruptive and also the fact that owing to the location of the phone, their was little privacy to undertake their personal calls.

We were also told by patients during a number of visits that there were not always private rooms available when they had visitors. In some cases ward areas such as the dining room were used to host visits from family and friends. While we understand that some ward environments are limited on space, every effort should be made by organisations to ensure patients have suitable areas available to meet visitors in private.

When such concerns have been made to us regarding phone calls and visitors we have raised this directly with the organisation.

Do patients have access to regular activities and the therapies they need?

Are adequate activities provided?

Varied programmes of activities and therapies can have a positive impact on patients and their recovery. One of the most common themes raised with us during visits was the lack of meaningful therapies and activities available. Patients reported to us that activities are rarely available during weekends or during evenings and this can lead to prolonged periods of boredom.

Certain patients may have significant restrictions placed on them under the powers of the Act and are not able to leave the ward. Sufficient and varied activities are important for such patients to help promote their recovery and keep them stimulated.

Another common concern that was highlighted to us by patients was that planned therapies or activities could often be cancelled at short notice, generally due to the unavailability of staff to facilitate them. Unavailability of staff was normally due to sickness, staff shortages or staff being diverted to undertake other duties such as enhanced observation levels that often cannot be planned for. This was a great source of frustration to the patients we spoke with who reported that when cancellations of activities occurred they often remained on the ward with little to occupy themselves

The experience of Patients at Ward C

During our visit we observed a number of patients appearing bored and restless, staff felt that patients needed more stimulation throughout the day.

When we visit an organisation we always assess the availability of activities and review the weekly schedules of activities undertaken by patients. During a number of visits undertaken we observed no group or individual activities taking place.

The experience of Patients at Ward D

During the three days of our visit we saw little evidence of activities taking place. There was no regular plan of activities or external trips. Staff and relatives reported that for over a year there had been no external visits organised by the hospital.

The experience of Patients at Ward E

On the day of the visit there were limited activities being undertaken by patients. It was reported that when the Activities Co-ordinator was on leave there was limited cover available to enable staff to facilitate activities.

When we have found limited evidence of activities taking place we have escalated this as a concern to the organisation visited and have been asked to be provided with action plans about how this will be addressed.

Is the approach to care planning appropriate and are well developed care plans in place?

Are care plans detailed and appropriate?

During visits our Reviewers always review the care and treatment plans (CTP) of individual patients. CTPs of patients are considered against the Mental Health (Wales) Measure 2010 (the Measure). Part 2 of the Measure places duties on mental health providers in relation to the preparation, content, consultation and review of CTPs. We reviewed many good examples of CTPs during our visits which were detailed and had involved considerable engagement with the individual patient. This is to be encouraged and demonstrates good, thorough, patient centred care.

Our Reviewers did find examples, however, where issues with CTPs had to be raised with organisations. Some patients we interviewed were not aware of the details of their CTP, they had not been involved in its development, or they had not signed or received a copy of the documentation. This was evidenced when we reviewed CTP documentation.

Where such issues have been raised, we have asked organisations to ensure that patients are offered the opportunity to be involved in developing their CTPs and that they sign and receive a copy of the documentation.

Are adequate risk management and safeguarding arrangements in place?

The assessment of risks, and developing risk assessments to mitigate and manage such risks, is a vital part of care planning for each individual patient. Our visits highlighted variation in the detail and quality of risk assessments and how they were linked to other issues such as safeguarding.

It was often found that there was a lack of engagement with patients, relatives and carers in the identification of potential risk areas and developing strategies to minimise such risks and manage them. It was found in a number of cases that there was no clear evidence that patients had signed or refused to sign risk plans.

Risk assessments should be up to date and accessible for all patients. This is especially important in relation to patients who are detained via the criminal justice system, as such patients may have identified risks that will impact upon the conditions specified when section 17 leave is authorised. We viewed a number of risk assessments that were not held within patient notes and immediately accessible and some were out of date with no evidence to demonstrate they had or were to be reviewed. This is unacceptable and in all

circumstances where we were not satisfied with the quality or management of risk assessments this was raised with the organisation.

We observed in a number of our visits that organisations have implemented blanket approaches to risk management. Our reviewers found in one visit that caffeinated drinks were banned for all patients. While we acknowledge that caffeine may have an impact on mood or an adverse reaction with medication, in the best interest of patients all decisions regarding choice and care should be individually care planned and dealt with in the same way as any other risk or need. Patients should be given as much free choice as possible and blanket approaches are something patients reported to us as impacting on their daily lives.

Are the physical healthcare needs of patients being met?

Care and treatment plans for patients detained under the Act need to be holistic and not only address the mental health of patients, but also consider other aspects including any physical healthcare needs. Many detained patients in hospital have physical healthcare problems, these can be chronic conditions or those that develop after their admission. This needs to be reflected in their care plan and addressed as and when required.

We found overall that the physical healthcare needs of patients were reflected in their treatment plans and acted upon as and when necessary. We found patients were generally registered with local GPs and dentists and could access medical appointments as and when required.

However, we found instances where the care and treatment plans were not holistic in terms of physical healthcare needs and patients were having difficulties accessing the care they required.

The experience of Patient C

Patient C had a diagnosis of diabetes and at the time of our visit had a critical requirement for podiatry services. At the time of our visit the patient had not been referred to a podiatrist and was unsure if an appointment was forthcoming or being scheduled. We raised patient C's concern to the staff on the day of our visit and were subsequently advised an appointment had been scheduled.

The experience of Patients at Ward F

There were limited, routine, physical health checks being undertaken on patients at ward F . We also noted from reviewing patient records that a number had not received any physical health screening or checks on admission to the ward. In addition a number of patients at ward F were not registered with a local GP service.

The experience of Patients at Ward G

Access to a podiatrist was extremely limited and in some cases caused patients discomfort, increased immobility and there an unnecessary reduction in independence

Is Section 17 leave managed appropriately?

Section 17 of the Act gives a patient's Responsible Clinician the power to grant a patient a leave of absence from the ward. The duration of such leave can vary considerably and can last for a matter of hours, days or even weeks. This is dependent on the individual patient's circumstances and requires thorough consideration and risk assessment by the Responsible Clinician. Sometimes the requirements of section 17 leave may be that it is necessary for the patient to be escorted by members of staff from the hospital.

Section 17 leave is an important part of an individual's recovery and can be used effectively to promote confidence and re-build independence. The frequency and duration of section 17 leave usually increases as an individual is preparing for discharge from a hospital environment.

When we visit an organisation we always review the documentation relating to access to section 17 leave. We expect to see appropriate section 17 leave documentation completed which includes;

- details about the timescales of leave

- any restrictions/boundaries in place and that these have been discussed and agreed with the patient
- thorough risk assessments about the leave
- clear rationale for the granting or refusal of leave

Overall we found that section 17 leave was well documented and the relevant forms had been completed adequately. Good practice examples of well managed section 17 leave include;

- leave being risk assessed with conditions of leave being clearly set out on the leave form
- the form being signed by the patient's Responsible Clinician
- the outcome of the leave recorded in the patient's notes
- expired or cancelled leave forms being clearly indicated as invalid

However, we again found instances where section 17 leave had not been appropriately managed.

It was reported to us by a number of patients that section 17 leave was often cancelled at short notice due to limited staff numbers (in the case of section 17 leave that was planned to be escorted). This can have a detrimental effect on patients' therapeutic programmes and lead to disappointment among patients.

We found a number of instances were leave forms were not marked clearly as cancelled, withdrawn or expired. This can lead to confusion amongst ward staff about if a period of section 17 leave is still valid and accessible by the patient.

We reviewed a number of section 17 leave forms for patients who were on detention orders as a result of criminal proceedings. Leave for such patients can be restricted in terms of how it used and its frequency. It is usual practice for a copy of the current Ministry of Justice leave authorisation to be filed alongside the section 17 leave form. This is done to ensure the member of staff authorising the patient to leave the ward always checks the leave is ultimately permitted by the Secretary of State. This practice was not evident in all the records reviewed.

We found a number of section 17 leave forms where the patient had not signed the form to confirm they were in agreement with the leave and any stipulations contained on the form. Furthermore there was no explanation or statement provided about why the patient had not signed the form. All section 17 should be discussed with the individual patient, agreed and evidenced on the form and in their notes.

We also found instances where the individual ward visited did not actively monitor section 17 in terms of the outcomes of the leave for the patient. The Code of Practice states the outcome of leave, for example if it went well or whether the patient or staff had concerns about it, should be recorded in the patient's notes. Patients should always, as far as possible, be involved in conversations about their care and treatment and section 17 leave will form a significant part of this. Paragraph 28.17 of the Code of Practice details this.

Are staff aware of their responsibilities and are there sufficient staff in place to manage the case mix?

Our Reviewers discuss the operation of each ward they visit with the staff and patients to establish any issues that can impact on its effective daily operation.

One of the most common issues that was highlighted to our Reviewers related to staffing. We were told in a number of organisations by staff that they were often required to spend long periods of time completing paperwork and undertaking administrative tasks. Some staff expressed concern that they were unable to provide as much time interacting with patients as they would like.

We were also told by staff in several organisations that although mandatory training in key areas was available, it was often difficult due to staff shortages to attend. This was most common among nursing staff.

It was also highlighted in some organisations that there was a serious pressure on beds and this could cause delays in transfer of patients to more appropriate placements.

We have recommended to organisations where staffing issues were identified that a review of staffing levels was undertaken and to ensure that staff are afforded dedicated time for training and development needs.

Chapter 5: Conclusion and Next Steps

The findings in this report highlight the importance HIW’s role in monitoring the use of the Mental Health Act in Wales. The findings evidence that the roles fulfilled by our Reviewers and SOADs are crucial to upholding and protecting the human rights of some of the most vulnerable individuals in our society who have had their liberty restricted.

This report identifies issues and concerns that we observed during our visits along with areas of noteworthy practice. We encourage all relevant organisations to read this report and learn from both the issues and the noteworthy practice to help drive improvement in services.

We will continue to work with the organisations we visit with the aim of raising any concerns we have and ensuring these are rectified so the experience of patients is improved.

Appendix A

Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also *independent mental health advocate.*
After-care	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to SCT patients and conditionally discharged patients, as well as those who have been absolutely discharged.
Appropriate medical treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Approved Mental Health Professional	A professional with training in the use of the Act, approved by a local social services authority to carry out a number of functions under the Act.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.

Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the Mental Capacity Act 2005.
Care Programme Approach (CPA)	The CPA is a co-ordinated system of care management, based on a person centred approach determined by the needs of the individual. There are four key elements within CPA: a systematic assessment that includes identifying needs and assessing risks, the development of a care plan addressing the assessed needs, the appointment of a care coordinator who is a qualified health or social care professional to design and oversee the care plan, and regular reviews as appropriate to evaluate the progress of the care plan.
Carer	Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who requires support because of their mental health needs.
Child and Adolescent Mental Health Services (CAMHS)	Specialist mental health services for children and adolescents. CAMHS covers all types of provision and intervention - from mental health promotion and primary prevention and specialist community-based services through to very specialist care, such as that provided by inpatient units for children and young people with mental disorder.
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment.
Compulsory treatment	Medical treatment for mental disorder given under the Act
Consent	Agreeing to allow someone else to do something to or for you; particularly consent to treatment.

Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned"
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.
Doctor approved under section 12 (also 'section 12 doctor')	A doctor who has been approved by the Welsh Ministers (or the Secretary of State) under the Act as having special experience in the diagnosis or treatment of mental disorder. In practice, Local Health Boards take these decisions on behalf of the Welsh Ministers. Some medical recommendations and medical evidence to

	courts under the Act can only be made by a doctor who is approved under section 12. Doctors who are approved clinicians are automatically treated as though they have been approved under section 12
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
GP	A patient's general practitioner (or *'family doctor'*).
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales.
Holding powers	The powers in section 5 of the Act which allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS trust) Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Hospital order	An order by a court under Part 3 of the Act for the detention for medical treatment in hospital of a mentally disordered offender, given instead of a prison sentence or other form of punishment. Hospital orders are normally made under section 37 of the Act.

Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as *'section 17 leave'.*
Local Social Services Authority (LSSA)	The local authority (or council) responsible for social services in a particular area of the country.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health habilitation, intervention rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.

Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental disorder	Any disorder or disability of the mind. As well as mental illness, it includes conditions like personality disorders, autistic spectrum disorders and learning disabilities.
Mental Health Act Commission (MHAC)	The independent body which was responsible for monitoring the operation of the Act. The Health and Social Care Act 2008 abolished the MHAC. Its functions in relation to Wales transferred to the Welsh Ministers who delegated them to Healthcare Inspectorate Wales (HIW).
Mental Health Review Tribunal for Wales (MHRT for Wales)	A judicial body that has the power to discharge patients from detention, supervised community treatment, guardianship and conditional discharge.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Nearest relative	A person defined by section 26 of the Act who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.
Part 2	The Part of the Act which deals with detention, guardianship and supervised community treatment for civil (i.e. non-offender) patients.

	Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act.
Part 3	The Part of the Act which deals with mentally disordered offenders and defendants in criminal proceedings. Among other things, it allows courts to detain people in hospital for treatment instead of punishing them, where particular criteria are met. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for Treatment.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term *'patient'* should be used in practice in preference to other terms such as *'service user', 'client'* or similar. It is simply a reflection of the terminology used in the Act itself.
Place of safety	A place in which people may be temporarily detained under the Act. In particular a place to which the police may remove a person for the purpose of assessment under section 135 or 136 of the Act. (A place of safety may be a hospital, a residential care home, a police station, or any other suitable place).
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.*
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.

Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under section 41 of the Act, to a limitation direction under section 45A or to a restriction direction under section 49 The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Revocation (and revoke)	Term used in the Act to describe the rescinding of a community treatment order (CTO) when a supervised community treatment patient needs further treatment in hospital under the Act. If a patient's CTO is revoked, the patient is detained under the powers of the Act in the same way as before the CTO was made.
SCT patient	A patient who is on supervised community treatment.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 12 doctor	See doctor approved under section 12.
Section 57 treatment	A form of medical treatment for mental disorder to which the special rules in section 57 of the Act apply, especially neurosurgery for mental disorder (sometimes called psychosurgery).
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.

Supervised Community Treatment (SCT)	Arrangements under which patients can be discharged from detention in hospital under the Act but remain subject to the Act in the community rather than in hospital. Patients on SCT are expected to comply with conditions set out in the community treatment order (CTO) and can be recalled to hospital if treatment in hospital is necessary again.
Three month period	The period of three months from when treatments to which section 58 of the Act would apply are first administered.
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.