Care Quality Commission

Humber NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV936	Willerby Hill	Ullswater	HU13 9NW
RV936	Willerby Hill	Swale	HU13 9NW

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust.

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

- The patient on Ullswater ward was admitted 23 months ago as an emergency placement, which was supposed to be for a period of three weeks, until a permanent future placement was ready for him.This placement subsequently became unavailable and he had remained in the seclusion room whilst alternatives were looked at.
- On the day of our visit, the seclusion area on Ullswater had an acrid smell of urine and we could see by observing in the seclusion room that there was food splattered on the walls
- The trust policy on seclusion was dated 2011 and was due for review in 2014. The current policy was out of date, as it did not take account of the requirements of the Code of Practice, which came into effect in April 2015.
- We were unable to find any evidence that attempts to create a structured routine were being tried for the patient on Ullswater.
- There was no care plan in place to address this patient's personal care. There was no exit plan for termination of seclusion for the patient on Ullswater.
- On Ullswater, the medical review documentation referred to "continue with plan", but we were unable to find where the seclusion plan was recorded and staff were unable to source this for us.
- Whilst we were told that the arrangements for reviewing the patient's seclusion on Ullswater were agreed by the MDT, we were unable to locate where this was recorded. There was clear evidence available in the patient's file that medical reviews were occurring once in every 24 hour period. However, we were unable to find evidence that the reviewing of this patient's seclusion met the requirements of either seclusion or longer term segregation as outlined in the Code of Practice.
- Staff told us that it was difficult to persuade the patient on Ullswater to take a shower and that he was currently refusing to do so. There was no care plan in place to address this patient's personal care or physical cleaning of the environment.
- Staff expressed concerns about the physical health of this patient because of the time he spent kneeling and the fact that he was kneeling in urine some of the time.
- We reviewed the notes of the patient secluded on Ullswater ward. There was limited information available within the files about this patient's likes, routines, and means of expression.
- On Ullswater we were informed that the multi-disciplinary team (MDT) had agreed the frequency of medical and multi-disciplinary reviews, but we were unable to find where this had been documented. We were also unable to conclude that the reviewing of this patient's seclusion met the requirements of either seclusion or longer-term segregation as outlined in the Code of Practice.
- The trust did not have a longer-term segregation policy despite having two patients in seclusion one on Ullswater and one on Swale ward. who would meet this definition. Reviews of their ongoing need for seclusion were agreed by the MDT and did not appear to meet the procedural safeguard requirements of the Code of Practice for either seclusion or longer-term segregation.

However:

- We undertook a further visit on the 10 December 2015.By that time, the provider had opened up a further seclusion room for the patient to allow him to be moved into a different room to facilitate deep cleaning of the rooms and to encourage him to use the shower.Care plans were in place for his management in seclusion and he had care plans for his activities, his personal hygiene, his environment, his physical health, his nutrition, his snacks, his communication, his routine, managing his violence and aggression, his activities and his family contact.Staff had begun to implement these care plans.
- The physical layout of the seclusion rooms on Ullswater and Swale met the requirements for of paragraph 26.109 of the Code of Practice.

Summary of findings

- We were informed that the views of his carers were constantly sought, although we were unable to speak to them. That the independent mental health advocate (IMHA) was involved and included in all meetings to discuss this patient's care and treatment

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

- The patient on Ullswater ward was admitted 23 months ago as an emergency placement, which was supposed to be for a period of three weeks, until a permanent future placement was ready for him.This placement subsequently became unavailable and he had remained in the seclusion room whilst alternatives were looked at.
- On the day of our visit, the seclusion area on Ullswater had an acrid smell of urine and we could see by observing in the seclusion room that there was food splattered on the walls
- The trust policy on seclusion was dated 2011 and was due for review in 2014. The current policy was out of date, as it did not take account of the requirements of the Code of Practice, which came into effect in April 2015.
- We were unable to find any evidence that attempts to create a structured routine were being tried for the patient on Ullswater.
- There was no care plan in place to address this patient's personal care. There was no exit plan for termination of seclusion for the patient on Ullswater.
- On Ullswater, the medical review documentation referred to "continue with plan", but we were unable to find where the seclusion plan was recorded and staff were unable to source this for us.
- Whilst we were told that the arrangements for reviewing the patient's seclusion on Ullswater were agreed by the MDT, we were unable to locate where this was recorded. There was clear evidence available in the patient's file that medical reviews were occurring once in every 24 hour period. However, we were unable to find evidence that the reviewing of this patient's seclusion met the requirements of either seclusion or longer term segregation as outlined in the Code of Practice.
- Staff told us that it was difficult to persuade the patient on Ullswater to take a shower and that he was currently refusing to do so. There was no care plan in place to address this patient's personal care or physical cleaning of the environment.
- Staff expressed concerns about the physical health of this patient because of the time he spent kneeling and the fact that he was kneeling in urine some of the time.
- We reviewed the notes of the patient secluded on Ullswater ward. There was limited information available within the files about this patient's likes, routines, and means of expression.
- On Ullswater we were informed that the multi-disciplinary team (MDT) had agreed the frequency of medical and multi-

disciplinary reviews, but we were unable to find where this had been documented. We were also unable to conclude that the reviewing of this patient's seclusion met the requirements of either seclusion or longer-term segregation as outlined in the Code of Practice.

- The trust did not have a longer-term segregation policy despite having two patients in seclusion one on Ullswater and one on Swale ward. who would meet this definition. Reviews of their ongoing need for seclusion were agreed by the MDT and did not appear to meet the procedural safeguard requirements of the Code of Practice for either seclusion or longer-term segregation.

However:

- We undertook a further visit on the 10 December 2015.By that time, the provider had opened up a further seclusion room for the patient to allow him to be moved into a different room to facilitate deep cleaning of the rooms and to encourage him to use the shower.Care plans were in place for his management in seclusion and he had care plans for his activities, his personal hygiene, his environment, his physical health, his nutrition, his snacks, his communication, his routine, managing his violence and aggression, his activities and his family contact.Staff had begun to implement these care plans.
- The physical layout of the seclusion rooms on Ullswater and Swale met the requirements for of paragraph 26.109 of the Code of Practice.
- We were informed that the views of his carers were constantly sought, although we were unable to speak to them. That the independent mental health advocate (IMHA) was involved and included in all meetings to discuss this patient's care and treatment

Summary of findings

Information about the service

Humber NHS Foundation Trust provides secure inpatient mental health services for adults aged 18 to 65 years old.

Ullswater was a 12 bedded medium secure unit for male patients with a learning disability. Only ten of the beds were operational and, on the day of the visit, there were eight patients resident on the ward. All patients were detained under the Mental Health Act 1983 (MHA). A patient who had been secluded/segregated for the past 23 months occupied one of the seclusion rooms. A second patient from Ullswater ward was also subject to seclusion. He was being secluded on the adjacent ward (Swale) in order to protect his privacy and dignity. The patient on Ullswater ward was admitted 23 months ago as an emergency placement, which was supposed to be for a period of three weeks, until a permanent future placement was ready for him. This placement subsequently became unavailable and he had remained in the seclusion room whilst alternatives were looked at

Our inspection team

Patti Boden Inspection Manager and a Mental Health Act reviewer

Why we carried out this inspection

We inspected this core service due to the CQC receiving a significant safeguarding alert from the National Autistic society. This was reported to the local authority safeguarding authority

How we carried out this inspection

This was an unannounced inspection on the 01 December 2015 to examine the use of seclusion on Ullswater ward at the Humber Centre. Then a follow up visit on 10 December 2015.

During the inspection visit, the inspection team:

- visited the seclusion rooms of Ullswater and Swale wards.
- spoke with two patients who were using the seclusion facilities.
- spoke with the ward manager, modern matron and clinical care director.
- reviewed the trust's policy on seclusion.
- scrutinised the seclusion documentation for the patient secluded on Ullswater ward.

Areas for improvement

Action the provider MUST take to improve

- The team must put care plans in place for the patient on Ullswater which include structured routines, physical healthcare, physical environment.
- The team must implement an exit plan for termination of seclusion for the patient on Ullswater.
- The Ullswater team must ensure that the reviewing of this patient's seclusion met the requirements of either seclusion or longer term segregation as outlined in the Code of Practice.

Summary of findings

- The trust must ensure that the seclusion policy is updated in line with the changes within the Mental Health Act Code of Practice which were to be implemented by October 2015.

Humber NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ullswater	Willerby Hill
Swale	Willerby Hill

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Ullswater ward was arranged around a secure courtyard area. There were a number of communal spaces available to patients on this ward which included a television lounge, two activity rooms, a rehabilitation kitchen and a relaxation room. En-suite bedrooms and communal spaces were arranged in and amongst each other rather than having dedicated corridors for each. There were two seclusion rooms next door to each other at one end of the ward. The accessible bathroom was located next door to these. A second off-ward bathroom was also available to patients as was an education room. Staff informed us that patients had access to a sports hall, gym and a further outside area.

On Swale ward, we only reviewed the seclusion suite.

The seclusion rooms on Ullswater and Swale met the requirements of paragraph 26.109 of the Code of Practice. Each seclusion room had an observation area and small anteroom, which could be used as an extra care area. There was comfortable seating in the anteroom next to the occupied seclusion facility on Ullswater. Each seclusion suite had adjacent toilet and showering facilities. We noted that whilst the seclusion rooms had relatively small observation panels, they contained parabolic mirrors and had CCTV to enable staff to observe the secluded patient. Staff could control the temperature and lighting from outside the seclusion room and there was a two-way intercom to aid communication. Each seclusion room had a small hatch through which staff could pass medication and food to the patient. The hatch was also opened to facilitate communication. A clock was brought into the observation area when the seclusion room was occupied so that patients could see it.

A patient who had been secluded for the past 23 months occupied the seclusion room on Ullswater. They had been placed there as a temporary placement whilst a bed in a long term placement became available. This placement did not then become available. A second patient from Ullswater ward was also subject to seclusion. He was being secluded on the adjacent ward (Swale) in order to protect his privacy and dignity. This second patient had recently been involved in a serious incident on Ullswater ward and he had become such a significant risk on the ward that the trust had arranged for an admission to high secure care for him. The care team were waiting for a bed to become available.

Staff nursed the patient in the Ullswater seclusion room with the door open, although they would close it when he asked or when his behaviour warranted it. He appeared to spend his time knelt on the seclusion mattress. This patient was not always willing to use the toilet facilities and would often wet himself. On the day of our visit, the seclusion area on Ullswater had an acrid smell of urine and there was food splattered on the walls. Staff told us that it was difficult to persuade the patient to take a shower and that he was currently refusing to do so. It was also difficult for the staff to get into the seclusion room to clean it. In order to address this, a best interests meeting was held two weeks prior to our visit by the clinical team, but the minutes had not yet been ratified. As a result, this patient remained in an environment that smelled strongly of urine and staff were unable to physically intervene to clean either the room or the patient. There was no care plan in place to address this patient's personal care or physical cleaning of the environment

Staff expressed concerns about the physical health of this patient because of the time he spent kneeling and the fact that he was kneeling in urine some of the time. This had led to a best interests meeting in respect of his physical health. We learned that a detailed plan had been put in place following this for a doctor to examine and address his physical health needs

Safe staffing

We did not assess this during this inspection.

Assessing and managing risk to patients and staff

We reviewed the notes of the patient secluded on Ullswater ward. Staff had admitted the patient directly into seclusion where he had remained for 23 months. There was limited information available within the files about this patient's likes, routines, and means of expression. As this patient had a diagnosis of autism and had limited communication, it was difficult for him to express his needs directly. We were

informed that the views of his carers were constantly sought and that the independent mental health advocate (IMHA) was involved and included in all meetings to discuss this patient's care and treatment.

There was no care plan in place to address this patient's personal care or physical cleaning of the seclusion environment

We examined the seclusion record for the patient on Ullswater. As this patient had been in seclusion for 23 months, the records were extensive and held in three different files. Due to the length of time that the patient had been subject to seclusion, the multi-disciplinary team (MDT) had agreed new review arrangements.

The patient was under constant observation by two members of staff. These observations were recorded at least every 15 minutes as per the trust's seclusion policy. However, there appeared to be a deviation from the policy due to the length of time the patient had been secluded as nursing reviews were no longer happening and medical reviews were taking place every 24 hours. The procedural safeguards required by the Code of Practice state that seclusion should be reviewed by two independent nurses every two hours and by a doctor at least twice in every 24 hour period following the first multi-disciplinary review. The Code of Practice paragraph 26.139 states "Further MDT reviews should take place once in every 24-hour period of continuous seclusion".

The Code of Practice requires less frequent monitoring of patients subject to longer term segregation but stipulates the added safeguard that "regular three monthly reviews of the patient's circumstances and care should be undertaken by an external hospital" (paragraph 26.156). We were informed that the Ullswater MDT had agreed the frequency of medical and multi-disciplinary (MDT) reviews, but we were unable to find where this had been documented. We were also unable to find evidence that the reviewing of this patient's seclusion met the requirements of either seclusion or longer-term segregation as outlined in the Code of Practice.

We examined the trust seclusion policy version 4.02 which was dated 2011 and was currently under review. The current policy did not take into account the requirements of the updated Code of Practice issued in April 2015. The trust did not have a longer-term segregation policy despite having two patients in seclusion on this ward who would meet this definition. Reviews of their ongoing need for seclusion were agreed by the MDT and did not appear to meet the procedural safeguard requirements of the Code of Practice for either seclusion or longer-term segregation.

We were told that seclusion reports would usually be provided to the operations management group for the monitoring of seclusion. However, due to the length of seclusion in both cases, the director of nursing had informed the wards that it was only necessary to provide reports if there were any changes.

The inspection team were seriously concerned about the welfare of the gentleman in seclusion on Ullswater and immediately sent a letter to the chief executive of the trust. This was under section 64(1) of the Health and Social Care Act 2008 and under Section 120 (7) of the Mental Health Act 1983. Following this letter the Trust sent us information. These included:

1. Seclusion management plan.
2. Copies of care plans outlining, personal hygiene and daily routines and activities.
3. Best interests meeting minutes and action plan following this meeting.
4. Care and treatment review minutes.
5. Access report.
6. Date when Trust's seclusion policy will be ratified which was scheduled for January 2016, taking into consideration the change to the Code of Practice in April 2015. Providers should have had this in place by October 2015.
7. Plan as to how the environment will be adapted to meet the patient's needs in the short term.
8. Plan as to how his discharge planning will be managed in the long term.
9. Weekly progress updates for him from his care team.

We then undertook a further visit on the 17 December 2015. By that time, the provider had opened up a further seclusion room for the patient to allow him to be moved into a different room to facilitate deep cleaning of the rooms and to encourage him to use the shower. Care plans were in place for his management in seclusion and he had care plans for his activities, his personal hygiene, his environment, his physical health, his nutrition, his snacks, his communication, his routine, managing his violence and aggression, his activities and his family contact. We found that staff had begun to implement these care plans

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Track record on safety

We did not assess this during this inspection.

Reporting incidents and learning from when things go wrong

We did not assess this during this inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • We were unable to find any evidence that attempts to create a structured routine were being tried for this patient on Ullswater. • There was no care plan in place to address this patient's personal care, physical cleaning of the environment. • There was no exit plan for termination of seclusion. • The medical review documentation referred to "continue with plan", but we were unable to find where the seclusion plan was recorded and staff were unable to source this for us. • Whilst we were told that the arrangements for reviewing the patient's seclusion were agreed by the MDT, staff had not recorded this. There was evidence in the patient files that medical reviews were occurring once in every 24 hour period. However, the reviewing of this patient's seclusion met the requirements of either seclusion or longer term segregation as outlined in the Code of Practice

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust policy on seclusion was dated 2011 and was due for review in 2014. The current policy was out of date, as it did not take account of the requirements of the Code of Practice, which came into effect in April 2015. The trust did not have a policy for the longer-term segregation of patients