CARE QUALITY COMMISSION

MENTAL HEALTH ACT INVESTIGATION REPORT FEBRUARY 2013

All the material reproduced below is taken verbatim from the CQC report; names have been redacted.

15 February 2013

Outcome of our complaint investigation into Mental Health Act issues related to the care and treatment of your son Tom, at Eastway House

Our findings

Failures in communication by CWP with your son, his solicitor and nearest relative regarding key areas/actions by the Trust re the Mental Health Act

Your son was not provided with the support of an Independent Mental Health Advocate (IMHA) and you had to research this service for yourselves. We have spoken to the IMHA [name redacted], who has confirmed that this is indeed the case, but that he now supports your son. [name redacted]confirmed that historically he has found it difficult to engage with staff on this unit with regards to patients right to an IMHA.

The Code of Practice (COP) Chapter 20 explains the role of the IMHA.

CWP failed to adhere to the Code of practice in relation to IMHA services.

Failure to inform your son or his advocates of several changes to his Responsible Clinician (RC)

We reviewed this matter and found there had been changes of RC made and explored why this occurred.
We uphold your complaint about failures by CWP to inform Tom, and his nearest relative of changes of RC.

Actions by the Responsible Clinicians (RC)

We reviewed the matter of changes to the RCs and found that in one instance, changes of RC took place because the RC had not renewed his Section 12 and Approved Clinician status and therefore had no legal authority to act as Tom's RC.

The Code of Practice, Chapter 14 deals with the allocation or changing of an RC and makes reference to ensuring continuity of care.
We therefore uphold this aspect of your complaint as CWP had a duty to ensure that RC's maintained their approval status.

Seclusion

At our initial visit to Eastway House on 23 November 2012, we made it clear to the Trust that we considered locking Tom in the suite of rooms constituted seclusion and they had since agreed with this. It is clear however, despite this that consistent seclusion records are still not being kept.

Code of Practice 15.62 states – detailed and contemporaneous records should be kept in the patient's case notes of any use of seclusion. The reasons for its use, and subsequent activity. Local policies should require the records of each episode of seclusion to be reviewed by a more senior professional.
The Code of Practice 15.62 applies and has not been adhered to.

The Code of Practice at 15.54 states if the patient is secluded for more than eight hours consecutively or 12 hours over a period of 48 hours, a MDT review should be completed by a senior doctor or suitably qualified approved clinician, and nurses and other professionals who were not involved in the incident which led to seclusion.
The Code of Practice 15.62 again applies and has not been adhered to.

Some parts of the Trust seclusion documentation have not been completed.
The Code of Practice 15.62 again applies and has not been adhered to.

….We found from these sample records, staff do not adhere to the Code of Practice with regard to documentation for seclusion thus not affording Tom all the safeguards under the Mental Health Act that such adherence would provide.

Failure by the Trust to meet the Mental Health Act guidance in relation to people with autism

Specific training for staff to look after, communicate with and support patients on the autistic spectrum is not included in the Trust's mandatory training. The unit provided care and treatment for people with autism

We found evidence that Tom's needs in respect of his autism were not being met.

The Code of Practice, paragraph 34.27, states that if people with autistic spectrum disorders do need to be detained under the Act, it is important that they are treated in a setting that can accommodate their social and communication needs as well as being able to treat their mental disorder.

We therefore uphold this aspect of your complaint.

Discharge planning/CPA and Section 117 aftercare

The First Tier Tribunal (Mental Health) which sat at Eastway House on 13 December 2012, ordered Tom to be discharged from detention under the Act on a date deferred to 11 February 2013. This was deferred for an appropriate Bespoke Package of Care to be put in place in the community. The tribunal commented that they had serious doubts about the appropriateness of treatment at Eastway House.

On 24 December 2012….. assessments for Tom were sought as below.

28 December – provider 1[name redacted]; provider 2 [name redacted]

31 December – provider 3 [name redacted]; provider 4 [name redacted]; provider 5 [name redacted]

04 January – provider 6 [name redacted]; provider 7 [name redacted]; provider 8 [name redacted]; provider 9 [name redacted]; provider 10 [name redacted]

These providers were all offering inpatient/residential care not the home care package as detailed by the First Tier Tribunal (Mental Health).

We were very concerned that these inpatient assessments had been requested and that the Trust had allowed so many different providers to assess Tom, five on one day alone. This is not in line with the guiding principles of the **Code of Practice**, including the least restriction, respect and participation principles.

It would appear that the Trust and Trafford Council has not adhered to the directions issued by the First Tier Tribunal (Mental Health) to seek a Community Care Package for Tom and if it had not been for your efforts a package would probably not be in place by 11 February when the discharge happens.

The Code of Practice at 27.5 – After care is a vital component in patients' overall treatment and care. As well as meeting their immediate needs for health and social care, after-care should aim to support them in regaining or enhancing their skills or learning new skills, in order to cope with life outside hospital.

It is documented that Tom has lost many of his social and communication skills since being admitted to Eastway House. The inappropriate plans for further residential care would do little to help him to regain those skills.

The Code of Practice at 27.8 – PCTs and Local Social Services Authorities (LSSA) should take reasonable steps to identify appropriate after care services for patients before their actual discharge from hospital.

We found that the Trust and the LSSA did not take reasonable steps to identify an appropriate after-care package for Tom, until the First Tier Tribunal (Mental Health) ordered a bespoke homecare package and then it was you, the family who resourced the Provider.

The Code of Practice at 27.9 – The PCT and LSSA should consider putting practical preparations in hand for after-care in every case, but should in particular consider doing so where there is a strong possibility that the patient will be discharged if appropriate after care can be arranged.

No plans for a home care package were put into place before the First Tier Tribunal (Mental Health) on 13 December 2012.

The Code of Practice at 1.3 – People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on a person's liberty, having regard to the purpose for which the restrictions are imposed.

We found that the Trust and the LSSA did not consider the least restrictive option, instead looking for further options for in-patient/residential care.

The Code of Practice at 1.5 – Patients must be given the opportunity to be involved as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their view taken seriously.

You made it clear at the point of Tom's admission to Eastway House and at all times made it clear that you wanted Tom back home, yet we found that the Trust and the LSSA still pursued an in-patient/residential course until the First Tier Tribunal (Mental Health) instructed otherwise.

The Code of Practice at 1.6 – People taking decisions under the Act must seek to use resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of the patient and achieve the purpose for which the decision was made.

The Code of Practice at 27.8 relates to Aftercare and Section 117, and states that aftercare planning should start as soon as the patient is admitted to hospital. The records reviewed identify that Section 117 Aftercare is not referred to until 10 December 2012.

We found that the Trust and the LSSA did not seek out appropriate Providers for a home care package until instructed to do so by the First Tier Tribunal (Mental Health), despite the requests from you and your desire to have Tom at home.

Of course the Code of Practice at 1.8 says that the principles inform the decisions they do not determine them, there does not appear to us to have been much consideration given to the principles before making decisions for Tom by the Trust.

Conclusion

We are saddened by the poor experience Tom and you as a family have had during Tom's detention at Eastway House.

We have upheld areas of your complaint in relation to supporting Tom to access an IMHA, lack of communication from CWP to you in relation to changes of RCs' and in relation to the maintaining of their approval status under the Mental Health Act, seclusion, failure to meet the needs of a person with Autism, and failure to arrange aftercare in a timely manner.