AGENDA ITEM
3.5

MENTAL HEALTH ACT MONITORING COMMITTEE

ERRORS AND BREACHES OF THE APPLICATION OF THE MENTAL HEALTH ACT 1983 (OCTOBER 2020 –MARCH 2021)

Date of meeting	05/05/2021
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Mr Phil Lewis – Head of Mental Health Nursing Alison Thomas, Team Leader Mental Health act Office
Presented by	Mr Phil Lewis – Head of Mental Health Nursing
Approving Executive Sponsor	Executive Director of Primary, Community & Mental Health
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Mental Health Act office staff		SUPPORTED

ACRONYMS	
MHA	Mental Health Act
CTMUHB	Cwm Taf Morgannwg University Health Board
CAMHS	Child & Adolescent Mental Health Services

IHI	Institute of Healthcare Improvement
CTO	Community Treatment Order
RC	Responsible Clinician
CoPW	Code of Practice for Wales
AMHP	Approved Mental Health Professional

Summary

During Quarter 3 there were 19 minor errors whilst Quarter 4 there were 21 minor errors. This shows an improvement on quarter 1 and 2 where 41 and 31 were reported respectively

There were 2 fundamentally defective errors in Q3 and 2 recorded in Q4.

- **Q3**- The first incident relates to the use of the nurses holding power under S5 (4). The patient had agreed to Informal admission but was subject to a Community Treatment Order (CTO).

- The second incident relates to the use of the doctors holding power under S5 (2). The Form HO12 was not signed, dated or timed by the doctor who invoked the power. The nurse receipted the paperwork in the wrong part of the form.

- **Q4**- The first incident relates to the use of the Doctors Holding Power under Section 5(2). The Form HO12 had not been timed by the doctor completing the form, which had not been properly receipted by the nurse in charge of the ward.

- The second incident relates to a Section 5(2) Holding Power on a medical ward in the General hospital. The medical doctor accessed the required paperwork over the internet and erroneously completed the English version rendering the section invalid. The doctor did not state the time that the Section 5(2) was applied and the H1 form was not receipted. This issue was also picked up in quarter 2.

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to present data regarding errors and breaches that occurred during the application of the Act and to highlight learning and actions taken to reduce occurrence. The report covers Adult, Older Persons and CAMHS managed by CTMUHB. Activity is regularly monitored in the MHA Operational Group.

Section 15 of the Act allows for the rectification of statutory detention documentation completed by Doctors and AMHPs within 14 days of admission to hospital. Within this report it is helpful to consider the categories of errors & breaches of the Act.

1.2 Rectifiable Errors

These are minor errors resulting from inaccurate recordings which can be rectified under Section 15 of the Act. Examples include incomplete addresses and misspelled names.

The application or medical recommendation, if found to be incorrect or defective, may, within that period, be amended by the person by whom it was signed. Upon such amendments being made the application or recommendation shall have effect and shall be deemed to have had effect as if it had been originally made.

1.3 Fundamentally Defective

These are errors which cannot be rectified under Section 15 and render the detention unlawful, therefore resulting in a breach of the Act. Examples include unsigned section papers, incorrect hospital details or the wrong form being used. Medical recommendations and applications that are not signed cannot be remedied under Section 15 and therefore render the detention invalid.

Administrative and medical scrutiny of section documentation is carried out by the MHA Office and medical staff approved under Section 12 of the Act to ensure compliance and to identify any amendments needed within the target time limit. The majority of errors recorded within this report are minor, relating to demographics, but all breaches are reported via Datix to enable monitoring and for training to be put in place as necessary.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 (a) The total number of **minor** errors across all services in **Q3** was 19, which were all rectified within the time limit. This represents 8.76% of all detentions throughout quarter 3. This can be broken down further throughout localities as demonstrated in table 1.

Table 1

Area	Number of errors	% of minor errors	% of minor errors for all detentions
Merthyr	3	15.79%	11.54%
Cynon	4	21.05%	14.28%
Taff	4	21.05%	7.84%
Rhondda	1	5.26%	2.78%
Bridgend	3	15.79%	6.52%
Out of area	4	21.05%	13.33%
Total	**19**	**100%**	

(b) The total number of **minor** errors across all services in **Q4** was 21, which were also all rectified within the time limit. This represents 10.29% of all detentions throughout quarter 4. This can be broken down further throughout localities as demonstrated in table 2.

Table 2

Area	Number of errors	% of minor errors	% of minor errors for all detentions
Merthyr	4	19.05%	12.12%
Cynon	4	19.05%	13.79%
Taff	5	23.81%	14.71%
Rhondda	1	4.76%	3.22%
Bridgend	2	9.52%	4.26%
Out of area	5	23.81%	16.67%
Total	**21**	**100%**	

2.2 The majority of errors were due to the following.

- Incomplete addresses
- Misspelling of names and addresses
- Incorrect Local Authority stated

2.3 The MHA team have introduced basic scrutiny checklists on all wards. The intention is for the receiving officers / ward managers, along with the Approved Mental Health Act Professional (AMHP), to check the accuracy of the statutory documents at the point of detention.

2.4 In line with the Scheme of Delegation, the individuals responsible for this have been identified within the general hospital wards.

2.5 The MHA team have devised a training programme on basic receipt and scrutiny.

2.6 The aim is to reduce minor errors from being made and eliminate any fundamental breaches of the Act.

2.7 The total number of fundamentally **defective** errors across all services in Quarter 3 was 2, the same figure as in Q4. This is broken down below into localities in table 3 and table 4.

Q3

Table 3

Area	Number of errors	% of fundamental errors	% of minor errors for all detentions
Merthyr	0	0%	0%
Cynon	1	50%	3.57%
Taff	0	0%	0%
Rhondda	1	50%	2.78%
Bridgend	0	0%	0%
Out of area	0	0%	0%
Total	**2**	**100%**	

2.8 The first breach of the Act was in relation to a patient subject to a

Community Treatment Order (CTO), who had agreed to informal admission. When the patient asked to leave the ward, the nurse invoked their holding powers under S5 (4).

There is no provision within the Act to invoke section 5 holding powers for a CTO patient. If a patient is requesting to leave, they must be handed an official CTO recall notice, Form CP5, which allows for their lawful detention in hospital. If there is likely to be a delay in the RC issuing a recall notice, the ward staff can prevent the patient from leaving under common law doctrine of necessity.

2.9 The incident occurred on a Monday afternoon, which the MHA office were unaware of until the Wednesday.

Ward managers were immediately reminded of the importance of informing the MHA team of any detentions under the MHA, including any informal admissions of CTO patients.

2.10 Training guides have been displayed on the wards' training boards in the use of Section 5 holding powers for CTO patients. MHA training has been arranged for ward staff and doctors to include this subject.

2.11 The second incident related to the use of the Doctors Holding Power under S5 (2). The junior doctor completed the Form HO12, which was not signed or dated. The nurse receipted the document in the wrong section of the form, which the doctor should have signed.

2.12 As Section 15 of the MHA does not apply to Section 5, an amendment was not possible rendering the Holding Power invalid.

2.13 The doctor and ward manager were contacted by the MHA team and asked to inform the patient that they were no longer subject to detention under Section 5(2) of the MHA 1983 but were now an inpatient on an informal basis.

2.14 The RC reviewed the patient but deemed that detention under the MHA 1983 was no longer necessary.

Q4

Table 4

Area	Number of errors	% of fundamental errors	% of minor errors for all detentions
Merthyr	0	0%	0%
Cynon	0	0%	0%
Taff	0	0%	0%
Rhondda	0	0%	0%
Bridgend	2	100%	4.26%
Out of area	0	0%	0%
Total	**2**	**100%**	

2.15 The first breach of the Act was in relation to the completion of the Form HO12. The Doctor who invoked his holding powers under Section 5(2) failed to time the form. The nurse who receipted the form timed and dated that she had received it on one day but consequently signed to receipt it the following day.

2.16 This incident occurred overnight on Monday so the MHA office picked up this error on the Tuesday morning.

2.17 As the Section 15 does not apply to Section 5, an amendment was not possible rendering the Holding Power invalid.

2.18 The doctor and nurse in charge of the ward were notified and asked to inform the patient that they were no longer subject to detention under Section 5(2) of the MHA 1983 and were now an inpatient on an informal basis.

2.19 The RC reviewed on Tuesday and decided that the patient did not require detention under the MHA 1983.

2.20 The second incident relates to a Section 5(2) Holding Power on a medical ward. The medical doctor accessed the required paperwork over the internet and erroneously completed the English version rendering the section invalid. The doctor also did not state the time that the Section 5(2) was meant to commence and the H1 form was not receipted.

2.21 This incident occurred overnight on Monday so the MHA office picked up this error on the Tuesday morning.

2.22 The liaison consultant and ward sister were informed and asked to inform the patient that they were no longer held under Section 5(2).

2.23 The patient was reviewed by the liaison consultant and discharged as he did not require a MHA assessment.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 In Q3, the number of minor errors fell by 38.71% from 31 to 19. In Q4, this number rose by 10.53% from 19 to 21.

3.2. There have been 2 fundamental defective errors in both quarter 3 and quarter 4

3.3 In line with chapters 38.9 and 38.10 of the Cop, the MHA team have introduced basic receipt & scrutiny checklists for all wards. The MHA team are rolling out training on the "General Overview of the MHA 1983", to nurse practitioners across all sites in CTM. This will include receipt & scrutiny training to raise awareness of the importance of adhering to the scrutiny requirements under the Act.

3.4 Training has been arranged by an external provider, which will incorporate the use of the holding powers under Section 5 of the MHA 1983.

3.5 Due to fundamental errors within the District general Hospital Wards, the MHA team are in the process of updating the MHA SharePoint page so that it includes all relevant statutory paperwork and guidance. The MHA team will also facilitate a Health Board wide push via IT and SharePoint to raise awareness of the MHA SharePoint page.

4 IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability

	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not Required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Work with communities and partners to reduce inequality, promote well-being and prevent ill-health

5 RECOMMENDATION

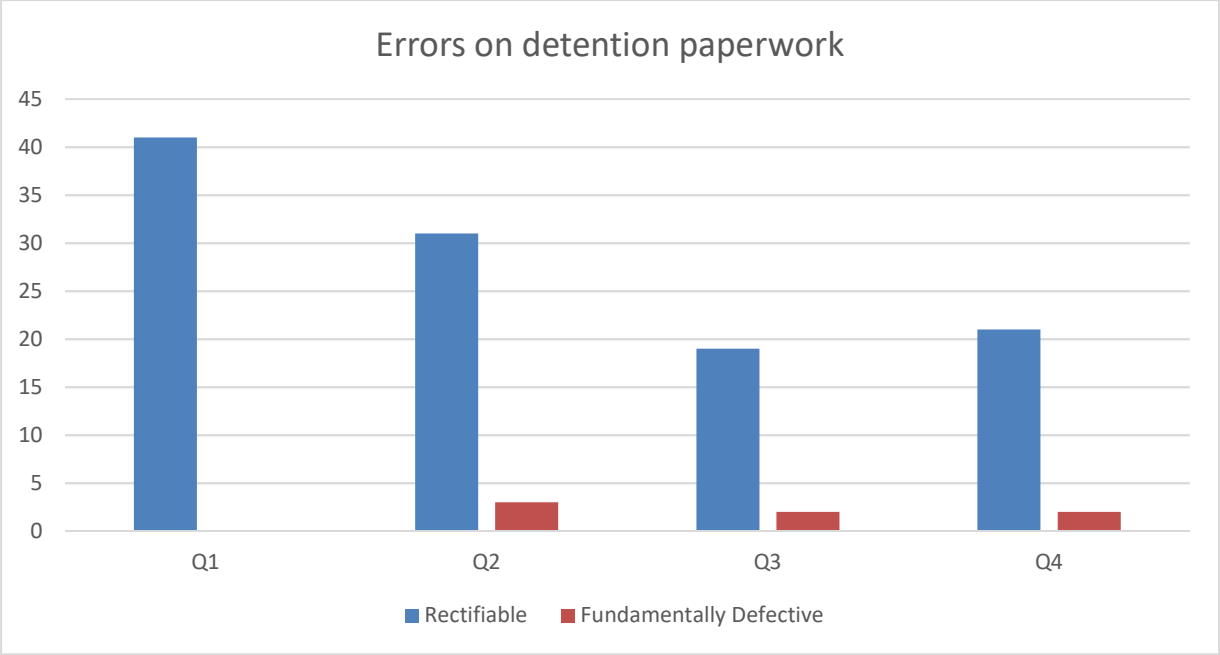
5.1 The MHA Monitoring Committee is asked to:

- **DISCUSS** the report
- **NOTE** the actions

Quarterly Summary

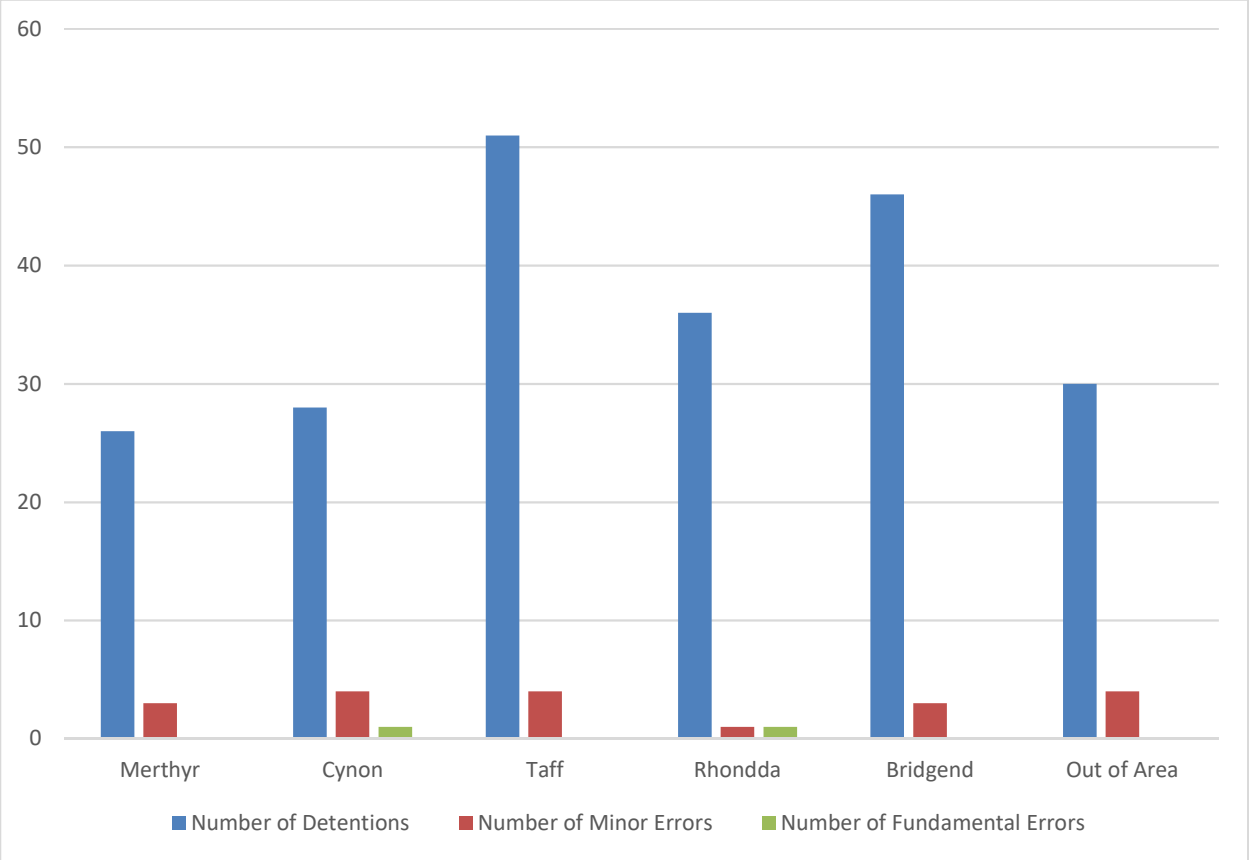
During quarters 3 & 4 of 2020/21, the minor errors on section papers across all disciplines were rectified within the 14-day time limit. There were 4 breaches of the Act during this period.

Summary Table (April 2020 - March 2021)



Category	Q1	Q2	Q3	Q4
Rectifiable	41	31	19	21
Fundamentally Defective	0	3	2	2

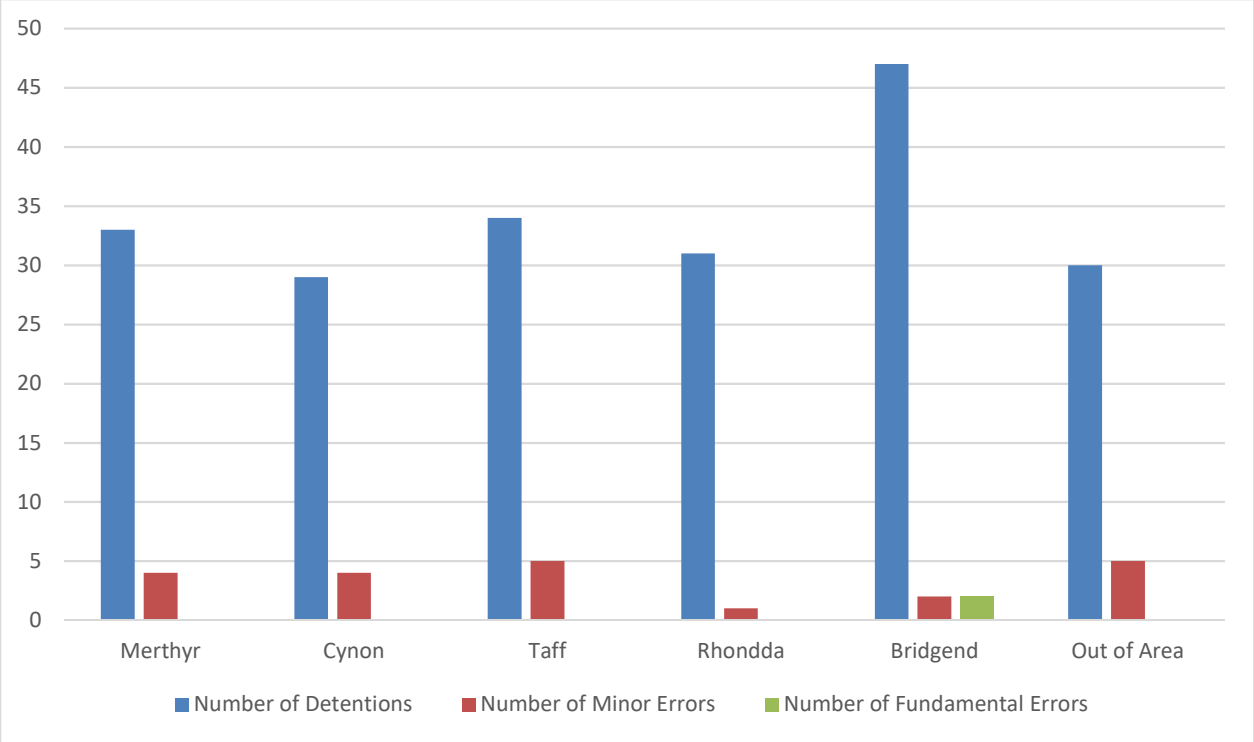
Total detentions per locality with number of minor and fundamental errors on detention papers for Q3 (October –December 2020)



Category	Merthyr	Cynon	Taff	Rhondda	Bridgend	OOA
Number of Detentions	26	28	51	36	46	30
Rectifiable	3	4	4	1	3	4
Fundamentally Defective	0	1	0	1	0	0

Total detentions per locality with number of minor and fundamental errors on detention papers in Q4

(January- March 2021)



Category	Merthyr	Cynon	Taff	Rhondda	Bridgend	OOA
Number of Detentions	33	29	34	21	47	30
Rectifiable	4	4	5	1	2	5
Fundamentally Defective	0	0	0	0	2	0