Mental Welfare Commission for Scotland

Report on announced visit to: Ward 4, Dr Gray's Hospital, Pluscarden Road, Elgin, IV30 1SN

Date of visit: 15 October 2019

Where we visited

Ward 4 in Dr Gray's Hospital is an 18-bedded acute psychiatric admission ward for adult and older age patients. The ward also provides care and treatment for young people, patients with a learning disability, and patients with autism. On the day of our visit there were 17 patients in the ward.

We last visited this service on 11 September 2018 and made recommendations about reviewing the provision of psychological therapy services to the ward, care planning, mental health act forms and activity provision. On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

Who we met with

We met with and reviewed the care and treatment of eight patients, and met with two relatives.

We spoke with the senior charge nurse (SCN), acting nurse manager, the lead nurse for mental health, and ward staff.

In addition, we met with a representative from the local advocacy service who was meeting with patients on the day.

Commission visitors

Tracey Ferguson, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

All the patients we spoke to during the visit advised that they felt they were receiving good care and treatment within the ward. All the patients described the staff as approachable, supportive, caring and always available for patients to talk to. Some patients reported that they felt safer in the ward environment. We saw staff engaging with patients positively and being proactive where patients were distressed.

Following the recommendation in relation to care planning from last year's visit, we wanted to review patient care plans to see if actions taken had led to improvements in the quality of these plans. The SCN told us during the visit that an audit programme has been undertaken and is currently in place. We heard that there is a working group to be set up to review all the current paperwork including the care plans as the audits have highlighted that the current paperwork is not fit for purpose. We would like to hear more about the outcome of the audits and will write directly to service about this.

What we saw within patient records was that, while there was some evidence of improvement, there was still work to be done to address the quality of the written care plans. We saw some care plans that were detailed, person-centred and addressed a wide range of needs arising from complex diagnosis; however, the standard was variable. We reviewed some files that lacked detail including physical health care needs. Evaluation of care plans were documented in the nursing progress notes however this lacked detail. It was therefore difficult to review progress of some patients as care plan interventions were not detailed and measureable in order to review goals achieved.

We also saw evidence of detailed initial assessments on admission along with risk assessments and risk management plans that were reviewed regularly.

We heard that the multidisciplinary team (MDT) meetings are held every day apart from a Wednesday. We were told that there are six adult consultant psychiatrists and two old age psychiatrists attached to the ward. We were told that this took up a large part of nursing time in order to attend these meetings. Patients were being well supported to attend, and participate in the meetings and we saw evidence in records that the patient, prior to the meeting had sat with their advocate or nurse to write down items that they wished to discuss as part of their meeting. Carers, relatives and service providers were also invited to attend these meetings if relevant and appropriate.

We saw good detailed recordings and outcomes of MDT meetings. However, the document varied across patients in regards to level of detail that had been written on the form.

We were told that pharmacy input to the ward commenced approximately 10 months, providing two sessions per week. Staff felt this was a positive change.

Access to occupational therapy (OT), psychological therapies and physiotherapy were available but were not part of the core MDT. We were able to review from files that some patients were receiving assessments and treatment from OT, and physiotherapy following referral.

In terms of psychological therapies, we were told that not much has changed since our last visit. Access to psychological services is via a referral form and there is a waiting list. However, we were told that if a patient who has psychological services in the community prior to admission that this input would continue, if appropriate, and that no patients currently on the ward are waiting for psychological therapies at this time. Although access to psychological therapies did not appear to be disadvantaging any individual patients at this time, we will seek an update from managers.

There was good attention to physical health care needs, including a full medical assessment on admission with regular physical checks, monitoring and referral to specialist service if required.

Recommendation 1:
Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals, ensuring that there is a care plan in place for all identified needs.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Use of mental health and incapacity legislation

Following the recommendation in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') documentation at last year's visit, we wanted to review patients files to see what improvements had been made.

Of the 17 patients on the day of our visit, 10 were subject to detention under the Mental Health Act.

We reviewed records for five of those patients and were pleased to see that the documentation to support the authorisation of their detention was easily located in the patients file.

We reviewed consent to treatment documentation and found a discrepancy for a patient between what was recorded on the consent to treatment (T2) and what was being administered. We followed this up on the day with the SCN.

Sections 281 to 286 of the Mental Health Act provides a framework within which restrictions can be placed on people who are detained in hospital. Where a person has been made a specific person in relation to these sections of the Mental Health Act, and where the restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific persons is regularly reviewed.

We found that restrictions has been placed on one patient. However, could not find the documentation in the file authorising this. We raised this with the SCN and were satisfied the documentation has been completed and the Commission had received a copy of this.

Rights and restrictions

The door to the ward was unlocked and patients could come and go freely.

For patients who are detained under the Mental Health Act we were able to see documentation that authorises time out of the ward and evidence of ongoing review. However, at least one patient we spoke to who was admitted on a voluntary basis and was aware of his rights felt that he could not just leave as he felt that he did not have permission. We discussed this matter further with staff and it is evident that patients are given information regarding status on admission, and this documentation is available on the ward and beside patients' beds.

We spoke with advocacy on the day of the visit and were told that strong links have been made with the ward. We were told that advocacy supports patients in tribunals, MDT meetings, individual meetings and that there is regular input to the ward.

The Commission has developed *Rights in Mind.*

This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Since our last visit nursing staff continue to provide activities within the ward. Feedback from patients was variable about activities. Patients told us that levels of activities can vary depending on clinical demand. Patients enjoyed the activities that were on offer. Others, however, felt there was not enough activities on the ward. On the ward there is a games room and we were able to see patients using this on the day of the visit.

We were pleased to hear from the lead nurse and clinical nurse manager that there are currently ongoing discussions about a new post to provide activity provision. We look forward to hearing about this development and will link directly with the service for an update.

During our visit we were informed of a recent service development involving the third sector, and Scottish Association for Mental Health (SAMH), who are supporting patients in their recovery plan and providing some activities. Staff are able to refer the patient to SAMH who will carry out an assessment and provide support to the patient whilst on the ward. Should a patient require a care package as part of discharge to the community, SAMH will also provide this. This was seen as a positive change and strong links have been made with the ward. However, it was unclear from reviewing patients' notes of the level of activity provision that SAMH are currently providing and its outcome.

Recommendation 2:

Managers should ensure that activity participation is recorded, evaluated and linked to patient care plan. Managers should develop a system that will allow the care provider to link their documentation with ward documentation.

The physical environment

The ward was in good decorative order compromising two dormitories and single rooms. Patients had no access to a garden, with the ward being situated on the first floor. There is a sensory garden in the grounds of the hospital which patients can access.

The ward did have space for activities. There was a games room that patients used to play pool, table tennis, table football, and gym equipment was available on the ward. There was space for patients to meet with visitors and quiet space on the ward should patients wish to use this. There was a kitchen so patients could make a cup of tea or coffee should they wish.

Any other comments

Closure of the stepdown service providing rehabilitation accommodation for patients discharged from hospital continues to have an effect on returning patients back into the community**.**

However we were pleased to hear about the changes that have been implemented across the service with SAMH supporting patients on discharge back to the community**.** We are keen to hear more about these developments on our next visit.

Summary of recommendations

1. Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals, ensuring that there is a care plan in place for all identified needs.
2. Managers should ensure that activity participation is recorded, evaluated and linked to patient care plan. Managers should develop a system that will allow the care provider to link their documentation with ward documentation.

Good practice

The information pack and guidance for informal patients is highly commendable.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON
Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons Inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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