Mental Welfare Commission for Scotland

Report on announced visit to: Castle Suite, Bellfield Centre, Livilands Gate, Stirling FK8 2AU

Date of visit: 30 October 2019

Where we visited

The Castle Suite provides short term intermediate care for older people who have a mental illness and/or dementia. The Castle Suite is based within the Bellfield Centre ('the Centre') and was registered with the Care Inspectorate on 23 November 2018.

The Centre consists of four units that provide intermediate care and integrated health and social care for older people. The Castle, Thistle, and Argyll Units are registered with the Care Inspectorate.

The Centre is located within the Stirling Health and Care Village campus. The Centre is a new development of the Clackmannanshire and Stirling Health and Social Care Partnership to provide integrated health and social care assessment to the people of Stirling and Clackmannanshire.

The Castle Suite is based on the lower ground of the Bellfield Centre and has 16 rooms. In addition, there are two generous independent living flats. On the day of our visit the unit had 14 residents. We were told that two individuals were being admitted on the day.

The staffing team within the Castle Suite includes senior support workers, registered nurses, social care workers, social care assistants and NHS therapists. The management team have a combined experience of NHS and social care. We were told that there is a consultant psychiatrist who provides cover to the Centre and a portfolio of community GPs that provide two sessions per week to the Castle Suite.

We were told by the registered manager that the aim of providing the intermediate care facilities to the individuals in the Castle Suite is to give encouragement, support and confidence in people to learn or re-learn the skills needed to be as independent as possible so that people can return to live at home or in their own community.

This was our first visit to the Castle Suite and on this visit we wanted to meet with residents and their carers/relatives. We also wanted to look at the legal authority of how individuals were being placed within the Unit.

Who we met with

We met with and reviewed the care and treatment of seven residents and met with four relatives.

We met with the registered manager and the depute manager. We spoke with the care staff and the Occupational Therapist (OT).

Commission visitors

Tracey Ferguson, Social Work Officer

Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

All the residents we met were happy with the level of care and support that they received and told us staff were approachable, caring and always available. Feedback from carers was generally positive, although some did raise some concerns that we discussed with staff on the day.

From reviewing the files we saw comprehensive documentation for staff to complete for each resident and all residents had intensive multidisciplinary input from the range of professionals involved.

We saw good examples of physical health care being addressed and ongoing reviews. We saw examples of physiotherapy and occupational therapy input as part of care and support. Where there were concerns about an individual's mental health, there was evidence of assessment and monitoring, and capacity assessments were requested and being carried out. Care plans were in place, though focussed on the professional interventions required.

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 here:

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

We saw recordings of multidisciplinary team (MDT) meetings. However, it was difficult to know who attended or contributed to these meetings. We saw some good examples of recorded actions and goals from these meetings although this was not the case in all files.

The Unit is providing short-term interim care for people either waiting to go home with a care package following assessment or awaiting guardianship or placement in another community facility, although it was difficult to know from the lack of recording in residents files what progress some residents were making towards moving on from the Unit.

We were told that the timescale for the intermediate assessment process is around six-to-eight weeks; however, we found that some residents had been in the Unit for several months either awaiting a care package, accommodation and/or guardianship.

Recommendation 1:

Managers should ensure care plans are person-centred, containing individualised information, reflecting the care needs of each person, identifying clear interventions and care goals, and are reviewed on a regular basis.

Recommendation 2:

Managers should ensure that clear actions are recorded as part of the MDT, along with discharge planning activity for individuals whose discharge has been delayed.

Use of mental health and incapacity legislation

Where it has been identified that an adult lacks sufficient capacity to make welfare decisions, staff need to consider whether authority under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') will be necessary to implement essential aspects of the care plan to which the adult is unable to give informed consent. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act.

Where the incapacity is in relation to consenting to a move from hospital to a non-hospital setting (for example, a care home), in specific circumstances it would be appropriate to use powers under section 13ZA of the Social work (Scotland) Act 1968. Section 13ZA should not be used as authority for implementing the transfer where the individual is actively resisting the move. The Commission has produced guidance on this issue and it can found here:

https://www.mwcscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf

On the day that we visited we were told by the registered manager that the criteria for admission to the Unit is that the individual must have capacity or, if they lack capacity, a legal proxy must be in place. We were also told that the Unit has six beds that are used for individuals who are awaiting guardianship; that eight individuals had a power of attorney in place, and that three residents had been assessed as having capacity. We were told that the three people placed in the care facility who had no legal proxy in place were placed in the Unit under s13ZA. We reviewed these individual files and saw evidence along with the reason as to why s13ZA had been applied to place the individual in the Unit. We spoke with the individuals on our visit who told us that they were happy to be in the Unit.

For individuals who had a welfare attorney or guardian in place, we saw a copy of the document in the file. In some files we saw that it had been recorded that a person was subject to the AWI Act. However, there was no evidence of this in the file and recording in this way led to confusion. We discussed this with the manager on the day who clarified that AWI had been recorded where only an s47 certificate was in place.

Where a person lacked capacity and had an appointed welfare attorney or welfare guardian in place, we did not see any delegation of powers to the Unit.

We suggest the use of the Commissions checklist for ease of ensuring guardianship details are contained in individual files. The checklist can be found on our website at:

http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate is completed by a doctor under section 47 of the AWI Act. We saw that s47 certificates were in place, accompanied by treatment plans relevant to the individual. However we found that where a legal proxy was in place that they were not always consulted, as the AWI Act requires.

The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf).

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give cardiopulmonary resuscitation (CPR). Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. 'Do not attempt CPR' forms were completed in some files with evidence of discussion with nearest relative or proxy as appropriate.

Recommendation 3:
Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.

Recommendation 4:
Managers should ensure that evidence of discussion with the proxy about how any powers are delegated to staff should be clearly recorded.

Rights and restrictions

The doors to the Unit are locked, with access and exit is controlled via keypad. We were told that a new locked door policy had recently been put in place for patient safety. We found that there was no sign up at the door to tell people about this policy. The locked door policy offers protection for individuals who have dementia and who lack capacity. Where a person lacks capacity, legal authority is required to place individuals in the Unit. We were satisfied that all individuals who were in the unit had the appropriate legal framework in place to support this.

On reviewing the files we were able to see that a restraint assessment had been completed for all individuals. The restraint related specifically to environmental restraint such as locked door, beds, and rails. In some files individuals who had been assessed as having capacity had signed this document and others not. Where a person lacked capacity there was no evidence or recording of a discussion with the legal proxy.

We were told that the Unit has made good links with the advocacy service and that advocacy has supported individuals at meetings.

Recommendation 5:
Managers should ensure that a copy of the locked door policy is displayed on the Unit door for individuals/ carers to view.

Activity and occupation

The individuals who we met with told us that there was not enough activity provision in the unit. Individuals told us that they were bored and there was not enough going on in the ward which made it a long day. Within the Centre there is a Community Hub, facilitated and co-ordinated by the third sector, which offers a hairdresser, library area, quiet space, cafe and group activities. Some of the individuals who we met with attended these group activities and

enjoyed these very much. Some individuals required staff to escort them to the activity which we were told was difficult to provide as this took staff away from the unit floor. We were told that there is no specific timetable and no specific staff member to carry out activities in the unit. We found no evidence within the notes of participation in activity sessions.

We spoke with the occupational therapist (OT) who provides individual activity which is based on the outcome of the assessment. The activity is related to specific goals/outcomes in order to support the individual to regain or rebuild new skills to move back to the community.

Recommendation 6:
Managers should ensure that there are structured activities being provided to the Unit and that that activity participation is recorded and evaluated.

The physical environment

The unit was spacious and bright with good decor. There was good dementia-friendly signage placed around the Unit. All bedrooms had en-suite facilities, and the two self-contained flats had technology for individuals to summon assistance if required. The flats had a small kitchen area in which individuals were able to cook their own meals. There was a large bright dining area where meals were served if individuals chose this option. Some individuals preferred to have their meals in their rooms and we saw this on the day we visited. There were a number of destination points throughout the unit where individuals were able to sit and rest. There were kitchen facilities that the individual or carer was able to use. There was an enclosed garden that individuals were able to access from the unit.

Any other comments

We were told that the Castle Suite offers a short-term intermediate care facility of approximately six-to-eight weeks for individuals who require the necessary intervention, support and treatment to then be able to back to the community. However, it has been recognised that individuals may experience a longer period of time in the Unit due to awaiting care packages or accommodation.

We heard that some individuals had several moves within the Centre before they were admitted to the Unit. However, the manager informed us that this has improved recently. This can cause distress for some patients and confusion for carers and relatives. The manager told us that a daily huddle happens every day in the Centre to discuss progress of individuals and bed management. The manager told us that discussions are taking place around barriers to discharge across the Centre as there are delays across all four units in the Centre.

Summary of recommendations

1. Managers should ensure care plans are person-centred, containing individualised information, reflecting the care needs of each person, identifying clear interventions and care goals, and are reviewed on a regular basis.
2. Managers should ensure that clear actions are recorded as part of the MDT, along with discharge planning activity for individuals whose discharge has been delayed.
3. Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.
4. Managers should ensure that evidence of discussion with the proxy about how any powers are delegated to staff should be clearly recorded.
5. Managers should ensure that a copy of the locked door policy is displayed on the Unit door for individuals/ carers to view.
6. Managers should ensure that there are structured activities being provided to the Unit and that that activity participation is recorded and evaluated.

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 The Care Inspectorate.

MIKE DIAMOND
Executive Director (Social Work)

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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