Mental Welfare Commission for Scotland

Report on unannounced visit to: Ettrick and Nithsdale Wards, Midpark Hospital, Bankend Road, Dumfries DG1 3TN

Date of visit: 26 November 2019

Where we visited

Ettrick Ward is a 19-bedded ward on the upper floor of Midpark Hospital in Dumfries. The remit of this ward is adult acute admissions, and it covers all areas of Dumfries and Galloway. The ward also admits people for planned detoxification primarily from alcohol. Care within the ward is overseen by three consultant psychiatrists.

On the day of our visit there were 18 patients on the ward, with one patient on pass from the ward. We heard that this ward consistently operates with high occupancy levels. There were no patients undergoing detoxification from alcohol on the day of this visit.

Nithsdale Ward is a 15-bedded ward which is adjacent to Ettrick Ward on the upper floor of the hospital, and is designated as an older adult acute admission service. Older Adult Care is managed by two consultant psychiatrists, supplemented by Acute Adult Psychiatrists, where appropriate and service covers all areas of Dumfries and Galloway. On the day of our visit there were 11 patients on the ward. Until recently, Nithsdale Ward accommodated adults over 65 but following a recent review of admissions to both Ettrick and Nithsdale Wards, this remit is being revised to include patients from age 60 which will be implemented in January 2020. In addition, patients from 55-75 will be assessed for the most appropriate clinical setting taking into account, physical co-morbidities, general frailty and vulnerability, social needs and risk.

This flexibility between both wards ensures that the care provided is tailored to individual need rather than being driven purely by chronological age. Overall, this has met with positive feedback, resulting in less disruption for patients moving between wards during an admission although there remained a gap at times in consultant follow up. We felt this should be easily resolved given the proximity of the wards.

We last visited this service on 23 January 2019 and made the recommendations relating to record-keeping, care planning, medication audit, occupational therapy (OT) provision and ward-based activities.

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/or reviewed the care and treatment of eight patients and one relative. This was an unannounced visit so patients and relatives were unaware of our attendance on the wards. Given the recommendations from the last visit, we looked closely at records during this visit to review progress in this area since then.

We spoke with the Lead Nurse Inpatient Services, two senior charge nurses, charge nurses, staff nurses, and health care support workers. We were keen to speak with this range of staff working across the two wards to hear about developments since our last visit when a number of issues were raised by staff in relation to service delivery. These concerns were

addressed by senior staff and we heard on the day that staff morale had improved overall. Managerial supervision is happening regularly, and clinical supervision is being explored further to enhance service provision.

Commission visitors

Yvonne Bennett, Social Work Officer

Margo Fyfe, Nursing Officer

Anne Buchanan, Nursing Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke to on the day were satisfied with the care and treatment provided within both wards and overall were complimentary about the staff involved in their care. They reported that they felt involved and included in discussions about their care and treatment and this was echoed by the relative we met on the day who highlighted good communication between himself and his relatives care team.

This inclusion was not though reflected in the records. Care plans remain generic, lacking in recovery and strengths-based content, with no evidence that the patient or their carer had been involved. Reviews were limited, lacking in evaluation, and identification of next steps and planning for discharge. It was difficult to discern progress or change in the patient's presentation and this was compounded by daily recording which is repetitive and makes it difficult to discern current relevant issues and interventions.

We heard that a new recording tool for multidisciplinary team (MDT) meetings had been piloted and was about to be introduced and we looked at this tool in patient records to see how this had changed since our last visit. While we saw some good examples of detailed records of these MDT's which recorded who had participated, discussions around key components of patient care and discharge planning. Overall these were inconsistent and variable and did not routinely provide a clear plan for the patients' care and treatment.

Risk assessments were recorded on the electronic system but not consistently stored in the same place within the system. They were not titled 'risk assessments' and were difficult to locate, even for staff on the day of the visit. It is important that all staff delivering care within an acute setting have a good working knowledge of risk for each individual and that to ensure this, risk assessments and management plans require to be accessible and current.

We heard that, following a recommendation from our previous visit, a process mapping exercise of the patient's journey had been completed which had identified the need to improve the current electronic system. In addition, an audit of internal transfers carried out also highlighted that multiple records make finding information difficult and time consuming. Having identified these issues, we heard that the service is engaging with other health boards to look at and improving electronic recording processes. This would appear to be a longer term solution but shorter term improvements now require to be prioritised. These issues formed the basis of recommendations following our last visit and although there is evidence of planning and discussion since then, we saw little change in the quality or content of this important aspect of the patient's care and treatment.

Recommendation 1:

Managers should ensure that improvement measures in relation to the quality and process of documentation and recording are now implemented.

As this was also raised at our last visit, we will bring this to the attention of senior managers for their response.

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

On the day of our visit, there were three patients in Nithsdale Ward and seven in Ettrick Ward who were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and we were able to access legal paperwork in all of these instances.

We looked at consent to treatment certificates (T2) and certificates authorising treatment (T3) for all patients who required these. We found a significant delay in the authorising of treatment (T2) and will write to the service separately in relation to this.

In addition, we suggested that T2 and T3 certificates should be accessible to nursing staff administering medication and that these could be copied and held with the drug prescription sheet for ease of access to ensure legal authority is in place. This was acknowledged by staff on the day and we heard that they had already considered this but would now action this to ensure clarity of authority for staff administering medication.

Rights and restrictions

On the day of the visit there were two patients who were subject to an enhanced level of observation although this was reviewed during our visit and there were no patients designated as specified persons. Sections 281 to 286 of the Mental Health Act provide a framework within which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied.

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/rights-mind/

Activity and occupation

We were pleased to hear that there has been increased involvement from occupational therapy services (OT) within the wards and saw evidence of assessments completed by the OT as well as cooking groups, walking groups, and gym groups. While the OT has been instrumental in developing these activities, the delivery of activity provision continues to rely on nursing staff and we saw that this is dependent on clinical need at any given time within the wards and activity provision is often cancelled due to competing priorities. One patient told us of the art therapy room within the ward which they felt could be more productively utilised if staffing would allow.

We were impressed with the commitment from staff to provide activities in the face of competing demands and discussed the potential for employing dedicated activity coordinators within the wards who could ensure that activity provision can continue at these times of high clinical need and it was agreed that this could be explored further by the service.

The physical environment

Midpark is a purpose-built facility which affords a high standard of accommodation for patients in single en-suite rooms. There is a variety of lounge facilities within the wards so that patients have a choice of where they choose to spend time.

Patients are highly complementary about the facilities the wards offer and value the privacy that the accommodation affords.

Summary of recommendations

1. Managers should ensure that improvement measures in relation to the quality and process of documentation and recording are now implemented.

Service response to recommendations

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

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

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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