Mental Welfare Commission for Scotland

Report on announced visit to: Wallace Hospital, 119 Americanmuir Road, Dundee, DD3 9AG

Date of visit: 14 November 2019

Where we visited

Wallace Hospital is an independent hospital providing assessment and treatment for adults who have a learning disability and complex needs. Wallace Hospital is currently registered for 10 adults.

We last visited this service on 15 November 2018, and made recommendations about care planning, consent to treatment documentation, and about section 47 certificates under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

On the day of this visit we wanted to meet with patients and look generally at how care and treatment was being provided because it was a year since our previous visit.

Who we met with

We met with and/or reviewed the care and treatment of all 10 patients during the visit.

We spoke with the deputy manager, the activity coordinator, and various members of the nursing staff during the visit.

Commission visitors

Ian Cairns, Social Work Officer

Claire Lamza, Nursing Officer

Philip Grieve, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Most patients in Wallace Hospital have limited verbal communication, and have significant communication difficulties. We did speak to several patients who raised no issues about their care and support in the hospital, and during our visit we observed positive interactions between patients and staff, and patients generally seemed content and relaxed in the environment. We did hear comments from a few patients who told us they were happy with their care and treatment, including one patient who was able to tell us specifically why they felt they were receiving appropriate care and support. They said that they felt safe and secure in the hospital, and that staff were involving them in discussions about their treatment, and keeping them up to date with the future plans for discharge. Another patient also told us about opportunities they had to do activities they liked.

On previous visits to Wallace Hospital we have highlighted that care planning documentation was person-centred and comprehensive, with evidence of regular reviews, but that the overall documentation was bulky and complicated. We felt that this raised questions about the usability of care planning information in practice, and made it difficult to get a clear picture of patient progress.

On this visit we saw that a new electronic care planning system was in place, and that with the introduction of this system the care planning process has been revised. Care plans now have a clear well-structured format, which records identified needs, have clear descriptions of interventions and of who will undertake these interventions, records information about what the individual person can do and the choices they can make, and set out the expected outcomes. We reviewed all the care plans on this visit, and the majority of them were comprehensive and detailed, and appropriately person-centred.

Risk assessments were well-completed, and were up to date and comprehensive, with evidence of review. We saw that daily risk assessments are completed, and in principle we felt that this approach was good, with a clear visual recording of the patients risk assessment status on that day. We also saw good guidance in positive behaviour support plans on how staff should manage stressed or distressed behaviours. We did see that one patient was being supported on a two to one basis for periods of time, but this was not reflected in the daily risk assessment status, or in their care plan. We also noted that the daily risk assessments for one patient were red, but we saw no information indicating why this continued to be the case, and no evaluation of a recorded plan to trial 1:1 observation. We also noticed that some individual plans had not been updated and were not accurate: for example a care plan relating to one patient inaccurately referred to their legal status as being an informal patient, when in fact they are subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Recommendation 1:

Managers should audit care plans to ensure that they are reviewed and updated, and accurately reflect interventions, particularly if identified needs have changed.

Recommendation 2:
Managers should ensure there is better linkage between the recording of risk on a daily basis and what is recorded or reviewed in care plans in relation to risks.

In the new electronic record system we saw that multidisciplinary team (MDT) meetings were well recorded, with information about who had attended the meeting, and with discussions and agreed outcomes clearly documented. Care needs are regularly reviewed in the MDT meetings, and also at regular care programme approach (CPA) meetings. We saw that comprehensive reports were prepared for CPA meetings by all the health professionals working with the individual patient, and we also saw evidence of family involvement in these meetings. We also saw evidence of patient participation in the MDT and CPA meetings, with documentation format encouraging patient views to be recorded. This was particularly clear on the CPA process, with a "Your CPA" report being completed in advance of a meeting, detailing the individual patient's views and any issues they wish to raise.

There is good multidisciplinary input within the service in Wallace Hospital. We saw physiotherapy, psychology, speech and language therapy, and occupational therapy input in individual patient files, and we saw specific specialist assessments such as sensory profiles being completed. There seems to be a strong emphasis on developing communication, which is particularly relevant because of the communication difficulties many patients have. The speech and language therapist had completed communication grab sheets for several patients, which provide good simple and straightforward guidance for staff about communication issues. We also saw ongoing assessments being undertaken by the speech and language therapist, with their input with individual patients being well recorded. The service uses a range of communication tools including talking mats and feelings boards, and a board with symbols to help staff explain to individual patients what is happening next in their daily timetable. We did see that several patients use Makaton signs, and we asked during the visit about training provided to staff in using Makaton sign language to communicate with patients. We were told that training has not been provided within the unit for several years, and that therefore a lot of staff who are now working in the unit are not familiar with Makaton signs. We were also told that this issue has been raised with managers by staff.

Recommendation 3:
Managers should arrange for training in using Makaton signs to be delivered to staff in the hospital.

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

Mental Health Act paperwork which we saw in individual files was well maintained.

When a patient is detained in hospital and is prescribed medication for more than two months then this must be authorised on either a T2 or a T3 certificate. We reviewed the drug

prescription sheets for all patients in the hospital who were detained under the Mental Health Act, and we saw that one patient was prescribed medication which was not authorised appropriately. We discussed this with staff at the end of the visit, and we have had a follow up discussion with the hospital manager. The previous psychiatrist who had been responsible for care and treatment within the hospital has recently moved, and the post has now been filled by two experienced consultant psychiatrists who have previously worked within the NHS, and consent to treatment documentation has been audited since our visit to ensure that all treatments are legally authorised.

Rights and restrictions

From information in files we saw that there is good input from an independent advocacy service.

We saw in MDT reviews that there was a section which indicated if incidents of stressed/distressed behaviour have reduced or not over the previous period, and felt this was an example of good evidence based practice.

Sections 281-286 of the Mental Health Act provide a framework which restrictions can be placed on people who are detained in the hospital. Where a patient is a specific person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of lease restriction is applied. We did see that one patient was a specified person and had appropriate Mental Health Act paperwork in place. However, we did not see a specific care plan in relation to the specific restrictions in place.

Recommendation 4:

Managers should ensure when a patient is a specified person in relation to Sections 281-286 of the Mental Health Act that a care plan is in place which sets out the specific restrictions which are in place.

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

General structured activity provision for patients in Wallace Hospital seems reasonable, and we heard positive comments from patients we were able to speak to about activities they are participating in. Activity provision is well recorded and evidenced, with information in files about activities which individual patients have been offered the opportunity to engage in, and information about what they are actually engaged in. The new electronic system is also able to set this information out in graph form, so staff can easily see over a period of time how individual patients are engaging in activities.

The physical environment

There is no designated garden area which patients in the hospital can access easily, because the hospital is on the first floor of the building. We also noticed on the day of the visit that,

while there was evidence of some recent refurbishment within the building, the physical environment was very cluttered and untidy in certain areas, most noticeably in the area which was functioning as a laundry. There was a clear lack of storage facilities, with washing baskets and clothes dryers creating potential trip hazards, and with limited storage for patient items and belongings, and we did feel on the day that in some areas in the building there were possible infection control issues.

On this visit, the Commission heard about the plans to register the ground floor of the Wallace Hospital building again as a hospital, opening 10 additional beds. With this new development the whole building will again be registered as a hospital, and both floors of the building will be refurbished as part of this new development. This will include refurbishment work being undertaken within the current Wallace Hospital environment, with plans to enhance services by creating a sensory room. This development will hopefully make the garden area more accessible to patients in the top floor of the building, but should also address the clear need to have better storage facilities within the building.

Recommendation 5:
Managers should ensure that plans to refurbish the current hospital environment as part of the planned new development address all the necessary environmental issues in the current Wallace Hospital part of the building.

Summary of recommendations

1. Managers should audit care plans to ensure that they are reviewed and updated, and accurately reflect interventions, particularly if identified needs have changed.

2. Managers should ensure there is better linkage between the recording of risk on a daily basis and what is recorded or reviewed in care plans in relation to risks.

3. Managers should arrange for training in using Makaton signs to be delivered to staff in the hospital.

4. Managers should ensure when a patient is a specified person in relation to Sections 281-286 of the Mental Health Act that a care plan is in place which sets out the specific restrictions which are in place.

5. Managers should ensure that plans to refurbish the current hospital environment as part of the planned new development address all the necessary environmental issues in the current Wallace Hospital part of the building.

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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