Mental Welfare Commission for Scotland

Report on an announced visit to: Clonbeith Ward, Ailsa Hospital Dalmellington Road, Ayr, KA6 6AB

Date of visit: 7 October 2019

Where we visited

Clonbeith Ward is a 12-bedded ward for male and female adults on the Ailsa Hospital campus in Ayr. The ward provides assessment and treatment for individuals over 65s who have complex care needs, functional psychiatric illness, with stressed and distressed behaviours. We last visited this service on the 30th May 2017 and made recommendations about the physical environment.

As part of the continuing redesign of the inpatient and community services in NHS Ayrshire and Arran, there is a process of resettlement and re-provisioning of services for the patients on the Ailsa site. We were informed of the planned redeployment of staff to Clonbeith Ward, due to the closure of a ward in the hospital. The charge nurse spoke of the impact this would have on the substantiated team and ways they could assist new team members with this transition. She highlighted that the service will provide staff training and also reflective practice sessions.

The ward is to be refurbished and the staff team have been consulted and involved in the planning process, we were told that our recommendations regarding the environment, from our previous report, would be addressed and implemented when this work took place.

Who we met with

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

We spoke with the senior manager inpatients, clinical service manager, senior charge nurse and other clinical staff who were on duty on the day.

Commission visitors

Mary Leroy, Nursing Officer

Yvonne Bennett, Social Work Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We saw staff being proactive and engaging with patients, and all the interactions we saw were warm, friendly and respectful. The patients we met with who were able to tell us about their experience of their care and treatment, were positive about the staff and the care they were receiving.

All the nursing care plans of the patients we reviewed were person-centred and recovery focussed. They were detailed in terms of both mental and physical health. The care plans involved building on strengths and activities and taking into account the patients' own goals and interests.

We noted that the Ayrshire Risk Assessment framework was embedded in practice. Those individualised plans were reviewed and regularly updated.

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

The multidisciplinary team meeting (MDT) is held on a weekly basis. The clinical decisions made during those meetings are clearly documented and generate an action plan with outcomes and treatment goals. There is input from medical, nursing, allied health professionals and pharmacy. The team can also access psychology and social work on a referral basis.

Patient and carer engagement.

Patient involvement in care is evidenced through participation in the ward review and in compilation of care plans. There is also a monthly community meeting within the ward, and at those meetings patients have the opportunity to discuss issues and concerns regarding their care and treatment, and make suggestions for ward activities. We were able to see the notes and action plan that were held on file about this process.

The team had many processes that augment good communication with carers and relatives. There were recordings on file of contact with relatives, and staff spoke of their overall commitment to involving carers and relatives in assessment and care planning where consent had been given. Families and carers are invited to the MDT meeting when appropriate.

The service use a standardised questionnaire which collates the views of carers. This process is to ensure that the ward provide a quality service, by exploring both the carers' experience of the service and their view on how their relative is being cared and treated.

Use of mental health and incapacity legislation

The copies of the certificates authorising detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 were filed in the patients notes, and also uploaded onto the

electronic system. On the front page of the patient's information there was also clear documentation of legal status, with a link to the electronic copy of the document.

We examined the consent to treatment certificates (T2) and certificates authorising treatment (T3) were in place for all patients who required them.

Section 47 of the Adults with Incapacity (Scotland) Act 2000 authorises medical treatment for people who are unable to give or refuse consent. Under s47, a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity. We noted s47 certificates and treatment plans, where required, were in place for patients.

When there was a guardianship order or power of attorney (PoA) in place, copies of the powers and contact details of the proxy decision maker are required to be on file. When we reviewed files one of the files recorded that there was a PoA in place, however we could not find copies of the powers on file. We raised this issue with the charge nurse on the day of our visit.

Recommendation 1:
Managers should ensure that staff are aware of and understand the powers and any restrictions in place for individual patients. When there is a proxy decision maker this must be recorded and the proxy decision maker consulted as appropriate.

Rights and restrictions

There were details on how to access the advocacy services which was readily available and, where relevant this was recorded in the patient's files, along with any legal representation that they had. On the day of our visit no patients were on an enhanced level of observation.

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

The majority of the activities on the ward are organised by the nursing staff. They are arranged on a one-to-one basis and are based on the patient's needs and strengths and, where possible, the patient's opinion. The staff organise community based social activities, quizzes, bingo, karaoke, music and light exercise.

An activity co-ordinator has been recently employed for the service. At present this provision is for two days a week for Clonbeith Ward. The activity co-ordinator's role is to further develop and enhance the programme of activities for the ward. We were told that following a period of implementation that both the time allocated and the benefit to patients would be reviewed. We look forward to hearing about the development of this initiative on our next visit.

The physical environment

The ward was clean, bright and well maintained to a high standard, using soft lighting and artwork to personalise the ward space. The sitting areas were well furnished and comfortable.

Patients' bedrooms were personalised with photos and belongings. The garden area was easily accessible by patio doors. The garden is enclosed and very pleasant, well stocked with plants, and very well-maintained. We were told by the staff that the garden space is well used, and that the hospital grounds have several walking paths that are frequently enjoyed by the patients.

Summary of recommendations

1. Managers should ensure that staff are aware of and understand the powers and any restrictions in place for individual patients. When there is a proxy decision maker this must be recorded and the proxy decision maker consulted as appropriate.

Good practice

We were told by the staff team about their development work relating to the falls prevention strategy. The process involves a multifactorial assessment of falls. The core component of this approach is through patient participation, team discussion and then generating strategies for fall prevention. We reviewed the documentation collated that states that over the past twelve months Clonbeith Ward have reported a 38% reduction in falls.

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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