Mental Welfare Commission for Scotland

Report on announced visit to: Loch View, Stirling Road, Larbert FK5 4AE

Date of visit: 14 January 2020

Where we visited

Loch View is an NHS assessment and treatment ward for adults with learning disability, autism, and complex health needs. Patients are accommodated across three houses with capacity for 20 patients in total. On the day of our visit there was two vacancies.

We last visited this service on 29 January 2019 and made one recommendation about the consultation and recording process when section 47 certificates under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') were being completed.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendation, and also wanted to hear about the progress of discharge planning for patients who have been in hospital for lengthy periods. This is because we are concerned about delayed discharge and the affects this can have on a patient and their families/carers but also the affects that this has on the capacity of the service being able to respond to those individuals who require admission.

Since the last visit, the Commission was aware of re-admissions to the Unit of patients who had been discharged to care homes out with the Forth Valley area. Discharge planning can become more complicated when the adult is outwith their own area. We heard about this on our visit and the impact of this on the discharge planning process.

On the day of our visit we were told about the active planning that was underway for some patients. However, since our last visit there has been little progress made regarding patients being formally discharged. We heard about active plans for patients who came under the funding responsibility of Falkirk Health and Social Care Partnership (HSCP). However, we were told this was not the case for the patients of the responsibility of Stirling and Clackmannanshire HSCP.

We were told that senior members of the service attend accommodation meetings with the HSCP to discuss accommodation and support for patients who no longer require to be in hospital. We felt this was good as it bridges the gap between inpatient and community services, and provides an integrated approach in the future planning for these complex patients.

For those whose discharge is not progressing the Commission will write to the relevant HSCP on an individual basis for further information.

Who we met with

We met with and reviewed the care and treatment of 11 patients, and met with two relatives and made contact with one relative by telephone.

We spoke with the head of learning disability nursing for both inpatient and outpatient learning disability services, the senior nurse, consultant psychiatrists, the senior staff nurses and staff of each house, and clinical psychologist.

Commission visitors

Tracey Ferguson, Social Work Officer
Yvonne Bennett, Social Work Officer
Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Relatives who we spoke with were pleased with the care and support that their relative received. On reviewing patient files we saw detailed minutes of multidisciplinary team (MDT) meeting with clearly recorded actions and outcomes. We saw that MDT meetings were being held regular and involved the wider multidisciplinary professionals and family/carers. Families told us that they felt involved in MDT and discussions around the care, treatment and support for their relative.

Where a patient's discharge had been identified as being delayed we saw recording in the MDT minutes of what actions were being taken. However, we felt that this varied in detail in the files that we reviewed. It was unclear from the files which patients were formally classed as delayed discharge.

From discussions with staff we were told that some patients are awaiting on suitable accommodation and, although it was recorded in the minutes that there was no accommodation, it was not clearly recorded how this was going to be progressed or escalated further. We suggested to managers that the Care Programme Approach Framework (CPA) framework may be useful documentation for staff to use. The CPA documentation is used to record risk assessment, multidisciplinary reports and management plans, as well as the ongoing care and treatment of the patient. The CPA model ensures that patients with a mental disorder associated with complex health and social care needs receive ongoing care support and supervision throughout their detention in hospital and rehabilitation into the community.

On the day of our visit, we were able to see from reviewing the files that staff were dealing with patients with complex needs. We found that most care plans were detailed and that the plans outlined the interventions that were required to meet the needs of the patient. Care plans were holistic in nature and covered a wide range of identified needs for each patient. We saw evidence that the care plans were being reviewed regular and really benefitted from the whole MDT input.

There were a few care plans that lacked detail so we discussed this further with the senior managers on the day. We saw evidence that physical annual health checks were being carried out.

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

We saw positive behavioural support plans (PBS) in place for patients and were told that some staff have had PBS training and others have been identified to undertake this training. The nursing staff told us that they found this training very beneficial and positive for the patients that they were working with.

From reviewing the files we saw that nursing staff continue to provide psychological therapies to patients. We were told that staff who are carrying out psychological therapies continue to have supervision with the psychologist. We were told that the units have access to psychology one day per week. We saw from files that that some patients were waiting on input from psychology. We saw good examples of psychological therapies and formulation planning happening. However, given the demand for psychological input, it was felt that the patient group may benefit from additional sessions from psychology, particularly give the high number of patients who are considered ready for discharge and the work involved in transition planning.

Recommendation 1:
Managers should undertake a review of the psychology service that is provided to the wards.

Use of mental health and incapacity legislation

On the day of our visit 12 patients were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). We found copies of the legal documents in the patients' files. Paperwork relating to treatment under Part 16 of the Mental Health Act was in good order, with relevant forms authorising medication being prescribed.

For those who had an appointed welfare and/or financial guardian in place we found copies of the orders in their files. 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. Section 47 certificates were in place and we saw that where a legal proxy was in place that consultation had occurred.

A number of patients have their funds managed by the hospital managers under Part 4 of the AWI Act and we saw good examples of where people had used their funds to either decorate their room, make more homely, personalised, or to plan holiday or outings.

The Unit uses the electronic system care partner to record and store information about each patient. In some cases the documentation was easy to find. However, as some patients have been in the ward for lengthy periods, we found that some legal documents were not so easy to find on the system. We spoke to nursing staff on the day and were aware that some documents had not been uploaded onto the electronic system and that the document was in the paper file. We discussed this further with senior managers and felt that an audit of most up to date legal paperwork should be carried out so staff can the easily access this.

Rights and restrictions

All three houses within Loch View operate a locked-door policy, which is appropriate to ensure the safety of the patients. There was a display of this policy on each of the house doors. On the day of the visit there was the appropriate legal authority in place to support this policy for the patient. Each patient has an individual risk assessment, which details what level of support the individual requires outwith the ward setting. This is shared with the support provider who provide support to a majority of patients in the community or hospital grounds.

During our review of files we saw care plans for a number of patients who require the use of restraint at times. These were audited and considered as part of the patient's review.

These were detailed and geared towards de-escalation in the first instance and, wherever possible, with physical restraint as a last resort to ensure the safety of the individual patient, other patients, and staff.

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

From reviewing the files we saw that patients had structured, person-centred activity plans which offered opportunities to participate in a range of social and recreational activities. We also heard about the continuing involvement of support from private providers for patients who are beginning to work towards discharge, to ensure the continuity and consistency as part of their transition to the community. During the visit some patients told us about their activities and how they enjoyed them and liked to go out. Some patients had pictorial boards displayed in their room which outlined their daily activities and enhanced their communication. Some of the regular ward activities that the patients enjoyed were complementary therapies, pet therapy, arts, crafts, music, walking groups.

Occupational therapy also offered a range of targeted, recovery-focussed interventions in line with individual patient goals identified within care plans.

The physical environment

Accommodation within the three houses is divided into one eight-bedded and two six-bedded units. The environments can become noisy at times, and are not best suited for patients who are sensitive to noise. Staff do try to manage this in as constructive a way as they can, but this can remain problematic for some patients. Each unit has a sensory room. Accommodation is spacious and bright, and offers a homely an environment as far as possible.

Small kitchen areas within the houses and over in the communal main building offer opportunities for patients to develop daily living skills, and the small lounges and dining areas are pleasant, well furnished, and comfortable.

Each house has access to an enclosed safe garden space, which is well used during better weather.

Any other comments

The staff team at Loch View are going through a transition stage due to the number of experienced staff who have either retired or left the service. The service is continuing to recruit for vacant posts and continue to use regular bank staff. We were told about the mentor system that is in place to support newly qualified staff which was positive. However, we are aware that this can place a demand on the more experienced staff. We spoke with a few newly

qualified staff who were enthusiastic and showed a real commitment and interest in working with people who have a learning disability and/or autism. We felt this was positive in the development of the staffing team at Loch View. On the day of our visit we saw good interactions with patients and staff.

Summary of recommendations

1. Managers should undertake a review of the psychology service that is provided to the wards.

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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