Mental Welfare Commission for Scotland

Report on unannounced visit to: Scolty Ward, Glen O'Dee Hospital, Corsee Road, Banchory, AB31 5SA

Date of visit: 25 February 2020

Where we visited

Scolty Ward is an older adult assessment unit for individuals with dementia, co-located on the same site as the local community hospital. It has 12 available mixed sex beds and there were 10 patients in the ward at the time of the visit. We last visited this service on 19 February 2018 and made the following recommendations: care plans should be more individualised and subject to regular evaluation; and bathing arrangements should be reviewed.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations. and also as it had been two years since the previous visit.

Who we met with

We met with and/or reviewed the care and treatment of six patients and one carer.

We spoke with the charge nurse and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Tracey Ferguson, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Patients and relatives we spoke with raised no issues about how staff provided care and support for them and we observed positive interactions between staff and patients throughout our visit. We found staff to be knowledgeable and enthusiastic regarding all their patients. We also saw in files that good information was collected from family members in 'Getting to Know Me' forms. This documentation encourages family and carer participation in providing life story information which helps to ensure that the wishes and preferences of each individual patient is part of the care planning process.

Documentation we reviewed in patient records was comprehensive and well-maintained. Care plans we reviewed were generally of a good standard, with information being focussed on the assessed needs of each patient. Some individual care plans could have had more details about specific nursing interventions but on the whole, plans contained appropriate individualised information and identified specific interventions and care goals. Care plans for stress and distressed behaviour did identify possible triggers to adverse behaviour but were less clear on the necessary actions to follow.

We felt that good attention is being paid in the wards to meeting physical health care needs. On the visit, we heard about good links which the service has with the other ward in the hospital where the focus is more on physical health needs and the ward also recruits nurses from this speciality to compliment the mental health nurses.

It was, moreover, less clear in files that the majority of care plans were being reviewed and evaluated to ensure that they remained meaningful .Some initial assessment care plans, for example, were still in place several weeks after admission. This was raised as a recommendation at the last visit and we were pleased to see that efforts had been made to improve on this in some files. This was clearly a new initiative and needs to be rolled out to all patient records.

Where there is no guardian or attorney for a person who cannot consent to a decision about whether to attempt cardiopulmonary resuscitation (CPR) in future, it is a requirement to consult with the close family, as well as trying to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. We found that where 'Do not attempt CPR forms' were on file, they were mainly completed with evidence of discussion with family members.

From discussion with staff on the day, and from file reviews, we observed that there is a strong emphasis in the ward, on carer involvement, and encouraging relatives/carers to participate in discussions about care and treatment. In many cases we reviewed, a family meeting had been held in preparation for discharge and a detailed record of the discussion and of the views of family members was recorded in the case file.

The multidisciplinary team meeting (MDT) is held on a weekly basis. The clinical decisions made during those meetings are clearly documented and generated 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.

In addition, the ward has a nursing post dedicated to family liaison and this enhances communication both with family and other community supports in order to improve opportunities for timely discharge.

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

Recommendation 1:

Managers should ensure that the regular evaluation of care plans initiated is rolled out to all care plans.

Use of mental health and incapacity legislation

There were no patients on the ward subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003. Patients who had a legal proxy (power of attorney or welfare guardian) under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') mostly had copies of the proxy powers on file.

Where individuals are assessed as lacking capacity to consent to treatment and they are being provided with treatment under Part 5 of the AWI Act, section 47 certificates authorising treatment should be completed. Copies of s47 certificates with treatment plans were in the files we reviewed. Many of the treatment plans did not include specific treatments authorised but simply had treatment plans of a generic nature. We also noted that copies of s47 certificates were generally kept in the individual patient medical files, and were not stored with the individual patient's medication chart. We would suggest a copy of this certificate should be kept with the medication chart so that it is clear to anyone administering medication what specific treatment is authorised by the Section 47 certificate. Also, where it has not been practicable for the doctor to discuss the certificate with a legal proxy, there should be a record of this having been attempted again at a later date.

Recommendation 2:

Managers should ensure that treatment plans for section 47 AWI Act certificates are discussed with the welfare proxy, specify the treatments authorised, and the certificates kept with the prescription records for ease of access.

Rights and restrictions

There appears to be good advocacy input into the ward. Ward staff also confirmed that the local independent advocacy service responds very quickly when referrals are made.

The door to the ward is locked for safety reasons and there is a notice to explain this. There is access to a very pleasant safe garden area and opportunities for patients to get fresh air daily.

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

On our last visit we saw evidence of good provision of activities, with regular planned group activities and more personalised one to one activity provision. Activity provision in the wards continues to be good and we observed this happening on the day of the visit.

The physical environment

The location of the hospital and space in the ward are ideal for its function as a dementia facility to local residents. Patients on the ward have easy access to a large garden area. We also noted work which has been done to create areas in the ward which are dementia-friendly with bold signage, an activity room, and quiet room with features to stimulate discussion.

The sitting room is a patient only space designed to allow patients increased privacy. Nevertheless, there is still adequate space for visitors in a large annexe en-route to the garden. Visitors also have a facility for making tea and coffee.

The inconsistent flooring patterns remains as before, as does the relative dearth of bathing facilities (only one bath and one shower for the whole ward). However, we were informed that managers have reviewed environmental issues raised at our previous visit but have been reluctant to make further modifications to the ward until its future provision is known.

Recommendation 3:

Managers must keep under review the need to upgrade the flooring and bathing facilities should the decision be made that the ward remains on site.

Good practice

There were very thorough medical reviews on file and progress monitored by the use of the neuro-psychiatric inventory. Patients with issues of stress and distress also had behavioural charts in place to review patterns of response to certain situations.

Summary of recommendations

1. Managers should ensure that the regular evaluation of care plans initiated is rolled out to all care plans.

2. Managers should ensure that treatment plans for section 47 AWI Act certificates are discussed with the welfare proxy, specify the treatments authorised, and the certificates kept with the prescription records for ease of access.

3. Managers must keep under review the need to upgrade the flooring and bathing facilities should the decision be made that the ward remains on site.

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 Healthcare Improvement Scotland.

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk