Mental Welfare Commission for Scotland

Report on announced visit to: Clava Ward, New Craigs Hospital, Inverness, IV3 8NP

Date of visit: 4 March 2020

Where we visited

Clava Ward is a twelve-bedded mixed-gender ward for adults over the age of sixty-five with a diagnosis of a dementia. The ward was full on the day of the visit. We last visited this ward on 31 January 2018 and made a recommendation in relation documentation relevant to the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). On the day of this announced visit, we wanted to meet with patients and follow up on this previous recommendation.

Who we met with

We met with and reviewed the care and treatment of six patients. We also met with the clinical area manager and the older adults' service manager at the beginning and end of the day, when we shared our findings. Whilst on the ward, we met with the clinical psychologist, the lead occupational therapist (mental health), registered nurses and health care assistants.

We heard about current plans to review the out-patient support to individuals with a dementia diagnosis, who exhibit stressed or distressed behaviour and who live at home. It is intended that the development of this service will prevent the need for admission to hospital for some individuals. This new team will also be able to offer crisis support and, we hope to hear of the development of this service in due course.

Commission visitors

Moira Healy, Social Work Officer

Claire Lamza, Interim Executive Director (Practitioners)

What people told us and what we found

Care, treatment, support and participation

Those patients who could speak to us, spoke positively about the support that they were receiving from all staff. At present the multidisciplinary team (MDT) consists of five consultant psychiatrists, nurses and junior medical staff. An occupational therapist (OT) and OT technician, both of whom work part-time between three wards. Specialist input from allied health professionals (AHPs) for example, dieticians, physiotherapy and speech and language therapy are arranged on a referral basis.

We met with the clinical psychologist, who is an integral member of the ward team and, who offers training on the Newcastle model of working with patients with dementia, who exhibit stressed and distressed behaviour. She teaches and supports trained nurses to create formulation plans to assist with effective management and well-being of individual patients.

With regard to staff training we were told that all registered nurses have completed their stress and distress training (Newcastle model) and the healthcare assistants will also be given training on this. It is hoped that this model of care will influence care planning.

When available in the files, patients' personal histories were well documented in the 'Getting to Know Me' forms. This provides valuable information in relation to patient's history and can be very helpful when drawing up activity plans.

We reviewed care plans, daily progress notes, MDT reviews and weekly ward round notes.

We heard that care plans were in the process of moving from one system to another; we found that currently they were variable in quality and reviews often lacked detail. There are different templates in use; those care plans that were using a standardised pro-forma for person centred plans were generally better detailed in terms of specific goals and interventions. We found that these were more personalised to the individual. The newer version appeared to be less person-centred and detailed. All of the care plans that we reviewed were lacking in terms of evaluation.

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 care plans are person centred and describe the specific interventions for the patient and are regularly evaluated.

Weekly ward rounds were often documented in chronological notes and not always easy to find.

MDT reviews took place on three to six month intervals (or as required) and were completed in separate coloured pieces of paper within the notes which made them easy to locate and follow the progress of the patient through their journey on the ward. The regularity and consistency of the detail and action plans in the reviews were variable. We understood this was possibly related to approaches of five different consultants who have input to the ward. We were told that that this lack of a consistent approach can be time consuming and difficult for the nurses to manage as each consultant follows a different pattern of working.

We were told that due to the significant distance from home, area social workers were often not able to routinely attend reviews, even when discharge planning was being actively planned for. At the time of the visit there were five patients whose discharges were delayed. We were told that delays were due to either awaiting for a guardianship order to be granted by the sheriff court or in relation to finding suitable resources in the community that would meet the patient's needs.

Recommendation 2:

Managers should audit MDT paperwork and take steps to ensure that care records are completed consistently.

Use of mental health and incapacity legislation

On the day of the visit six patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Where treatment without consent was required beyond two months this had been completed for five of the six patients; for the one patient that this had not been appropriately authorised. We raised this at the time, and the locality manager agreed to follow this up immediately.

We found documentation for patients who had a welfare power under the AWI Act were contained in all but one of the patient's care files. We discussed this with the ward staff present on the day of the visit.

Where an individual lacks capacity in relation to decisions regarding medical treatment under section 47 of the AWI Act, a certificate of incapacity should be completed by a doctor. We found that section 47 certificates were present in files that we reviewed and were accompanied by individual treatment plans that were filed with the drug prescription sheets, which is good practice.

Rights and restrictions

One patient we met with received medication covertly and a covert medication care pathway was in place and filed appropriately with medication sheets.

The Commission has developed the Rights in Mind Pathway designed to help staff in mental health services insure that patients have their rights respected in key points in their care and treatment, this can be found at https://www.mwcscot.org.uk/rights-mind/

Activity and occupation

We met with the occupational therapy lead for mental health, and discussed activity provision on the ward with the clinical area manager. There is currently no dedicated activity co-ordinator on the ward. We were told that there are plans to consider this as a time protected role in future workforce planning and we hope to be advised of the developments regarding this role as this would be beneficial to the patient needs.

We could see evidence of a range of activities that had been taking place within the chronological account of care for some patients and there was recent evidence of both ward based activities off ward activities.

The OT and OT technician are primarily engaged with assessing suitability for discharge home, although the OT assistant uses her time to offer opportunities for on and off-ward activities. The on-ward activities included going for a walk, gardening group and creative activities such as baking/cooking, drawing, and colouring in. Some of the off-ward activities were held in the hospital social centre and we noted that there were trips out of the hospital, for example visiting cafes or going further afield using hospital transport. Unfortunately there was no consistency of recording and no scheduled activity programme. We understand that this is because activity provision is nursing staff dependent and that this is only possible when staffing levels allow.

Recommendation 3:

Managers should review the current provision of therapeutic and recreational activity with a view to increasing the range of activity available for all patients, and ensuring that this activity is recorded in the patient's records.

The physical environment

The ward is spacious, bright and clean but is not a dementia-friendly design and had not been built with the purpose of caring for people with dementia. There is a significant amount of work that still needs to be done to make this environment dementia friendly.

Communal areas such as the combined dining room and lounge are busy and noisy with a TV on throughout the day. Noise reduction boards are being considered for walls and ceilings and moving the television into a small lounge would all help make this communal area quieter and more conducive to therapeutic activities. The flooring throughout the unit is unsuitable for the current patient group as the main areas are carpeted and likely to pose a falls and infection control risk

The windows and doors at the end of corridors leading to outside areas have been camouflaged to prevent patients from attempting to access a locked area and becoming distressed. However, the handles on the doors to the patients' bedroom are more in keeping with an acute ward, and are difficult to open. The walls lacked interesting objects on display.

All bedrooms were en-suite and the rooms were spacious. Patients were able to personalise their rooms. One patient spoke very positively about his bedroom and that he has his own shower and toilet that he does not need to share. However, there is only one bathroom, and

this is currently not being used, as the fixtures/fittings have not been adapted for this group of patients.

The ward has exclusive access to an enclosed courtyard area, but it was paved over and not suited to the needs of this patient group. It was uninspiring and lacked colour or interesting places to sit and plans to refurbish this area will require a significant investment. The value of looking out onto a green space and it being accessible and safe for this group of patients would create significant benefits; it would also provide an alternative space for visits.

Recommendation 4:

Managers should ensure that along with the current proposed modifications, a dementia environment assessment be undertaken, and action taken to implement the changes required to the environment.

Summary of recommendations

1. Managers should ensure that care plans are person centred and describe the specific interventions for the patient and are regularly evaluated.

2. Managers should audit MDT paperwork and take steps to ensure that care records are completed consistently.

3. Managers should review the current provision of therapeutic and recreational activity with a view to increasing the range of activity available for all patients, and ensuring that this activity is recorded in the patient's records.

4. Managers should ensure that along with the current proposed modifications, a dementia environment assessment be undertaken, and action taken to implement the changes required to the environment.

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.

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.

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