Mental Welfare Commission for Scotland

Report on announced visit to: Oak Ward, Inverclyde Royal Hospital, Larkhall Road, Greenock, PA16 0XN

Date of visit: 8 June 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's Routemap (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to- face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Oak Ward is situated within Orchard View on the Inverclyde Royal Hospital site. It provides care for 12 adults with complex care needs. We last visited this service on 27 September 2018, which was our first visit to the service following its opening in August 2017.

On the day of this visit we wanted to look at activity provision and care planning. This is because we are aware that activity provision has been significantly affected by the Covid-19 restrictions, as these ease we want to see how wards are re-establishing activity programmes.

Who we met with

We met with and/or reviewed the care and treatment of six patients and three carers/relatives/friends. We spoke with the service manager, the charge nurse and a student nurse on placement.

Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support and participation

We were advised that, throughout the pandemic Oak Ward has remained Covid-19 free. The ward continues a regime of regular staff testing and all patients and staff who wished to be vaccinated have received their second dose.

The consultants visit the ward and hold weekly multidisciplinary team (MDT) review meetings. There are twice weekly GP visits, and access to medical cover from the hospital duty doctor rota. This input has continued throughout the pandemic. There is good input from allied health professionals, with dedicated input from physiotherapy and occupational therapy, and other services such as speech and language therapy being readily available on a referral basis. During the pandemic some allied health professional (AHP) services were provided on a virtual basis, however these have all now recommenced on a face-to-face basis.

Three monthly MDT reviews were held for patients pre-pandemic. These have recommenced, and named persons/carers are again being invited to attend these now that restrictions allow. MDT decisions were clearly recorded and we found evidence of relatives/carers being consulted and informed regarding care decisions.

We found care plans in all the files we reviewed. The level of detail contained in the mental health and recovery care plans and the frequency of reviews varied, with some very detailed and some requiring further development as they did not fully reflect the recovery focussed work which was being undertaken. We found that physical health needs were being managed well and this was reflected in the care plans.

Care plans for stress and distress, where these were required, were also person-centred and contained information on early signs of distress, triggers and detailed strategies for distraction and de-escalation

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 review their audit processes to improve the quality of recovery focussed care plans to reflect the holistic care needs of each patient, and identify clear interventions and care goals.

Use of mental health and incapacity legislation

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003, ('the Mental Health Act') the current detention paperwork was present in the files.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required; however, two of these certificates did not cover all medication prescribed. Where a medication change is outwith that covered in the current T3, the responsible medical officer should contact the Commission to arrange a review by a designated medical practitioner. This was discussed with the charge nurse and service manager on the day, and the consultant contacted to have this addressed.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') this was recorded; however, there was not always a copy of the powers on file. We suggest the use of the Commission's checklist for ease of ensuring guardianship details are contained in individual files. The checklist can be found on our website:
http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf

Where individuals lacked capacity to make decisions about their health care, Section 47 certificates, which authorise treatment under the AWI Act, were in place.

One patient was receiving covert medication. There was a completed covert medication pathway in place, however this had last been reviewed in 2019 and marked as indefinite.

A link to our good practice guidance is included which sets out the process to be followed, including the need for regular reviews:
https://www.mwcscot.org.uk/sites/default/files/2019-06/covert_medication.pdf

Recommendation 2:

Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.

Recommendation 3:

Managers should commence a system of audit to ensure that, where relevant, copies of welfare guardianship powers and/or powers of attorney certificates are held within the individuals' care files.

Recommendation 4:

Managers should ensure that where covert medication is prescribed the covert medication pathway is completed and reviewed in line with our good practice guidance.

Rights and restrictions

The ward has a key fob entry systems. Staff let patients and visitors enter and exit the ward as required. The wards had access to pleasant, secure gardens which patients could access freely throughout the day. Patients had access to advocacy services.

Since the hospital is now in a level 2 Covid-19 restriction area, visiting has now opened up to two named visitors per person. Visitors are encouraged to book visit times to ensure all visitors can be accommodated whilst maintaining social distancing. We are advised by the ward this works well and all visit requests are being accommodated.

Outings from the ward have also recommenced. We heard of patients going out to local shops, or for a walk with their visitors. Since our last visit the ward has secured shared use of a minibus and has been utilising this to take patients out for runs, or more recently for lunch.

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

Prior to the pandemic the ward benefited from volunteer visits from Over the Rainbow, a group who provided music and movement sessions, and the Clydeside singers. Due to Covid-19 restrictions all these activities stopped, and there are no plans in place to re-establish these links yet.

Since our last visit the ward has access to a shared minibus. There are a number of drivers amongst the staff and weekly outings are being established. Currently, due to social distancing restrictions, only two patients can be taken out at one time. Staff advise that they are keen to re-establish regular outings for lunches, shopping cinema etc. as restrictions continue to ease.

The ward benefits from input from an occupational therapist (OT) two days per week; however, due to vacancies there is no OT technician input currently. The OT provides one-to-one sessions, these include cookery sessions and art and craft work. They also work with nursing staff to facilitate outings in the minibus.

Nursing staff provide activities such as quizzes, music sessions and games as staffing and clinical needs allow. However there is no designated patient activity co-ordinator within the unit to establish and oversee a programme of regular activities. We are advised that this role has been established in a number of other wards on site with good results, and the service manager is keen to see this developed across all wards.

We look forward to seeing further developments in activity provision on our next visit.

The physical environment

The ward is bright, clean, spacious, and benefits from access to enclosed courtyard gardens and a larger garden space which surrounds much of the unit. All bedrooms were single room en-suite. There are a number of small sitting rooms, enabling patients to have a choice with regard to how they spend their time.

There is a multipurpose activity/crafts room which is shared with Willow Ward. The unit also benefited from having a café within the main foyer of the building. This was used by patients, staff, and visitors, all of whom commented positively about the benefits of this facility. This was closed at the beginning of the pandemic. Unfortunately, we are advised that the provider of the service has withdrawn and there are currently no plans to reopen this valuable resource.

The ward has a large kitchen where patients can make meals or snacks, due to current restrictions this is being done on a one-to-one basis. There is also access to laundry facilities and patients are supported to do their own laundry.

Summary of recommendations

1. Managers should review their audit processes to improve the quality of recovery focussed care plans to reflect the holistic care needs of each patient, and identify clear interventions and care goals.

2. Managers should put an audit system in place to ensure that all medication prescribed under mental health or incapacity legislation are properly authorised.

3. Managers should commence a system of audit to ensure that, where relevant, copies of welfare guardianship powers and/or powers of attorney certificates are held within the individuals' care files.

4. Managers should ensure that where covert medication is prescribed the covert medication pathway is completed and reviewed in line with our good practice guidance.

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.

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