Mental Welfare Commission for Scotland

Report on announced visit to: Wards 4 A & B, Larkfield Unit, Inverclyde Royal Hospital, Larkfield Road, Greenock, PA16 0XN

Date of visit: 24 August 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 route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face-to-face visits This local visit was carried out face-to-face.

Ward 4 is located on the first floor of the Larkfield Unit which is part of the District General Hospital. The Unit has 20 beds for the assessment of older people and is designated as short stay. The ward is divided into two sub units; 4A provides 10 beds for people with dementia and 4B provides 10 beds for people with other mental illness. At the time of our visit there were six patients in 4A and three in 4B. We last visited this service on 9 April 2018 and made recommendations relating to proxy decision makers and the environment.

On the day of this visit we wanted to follow up on the previous recommendations and also look at care planning, activity provision, the use of the Mental Health (Care and Treatment) (Scotland) Act 2003, ('the Mental Health Act') and the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act')

Who we met with

We met with and/or reviewed the care and treatment of seven patients and two relatives.

We spoke with the senior charge nurse (SCN).

Commission visitors

Mary Hattie, Nursing Officer

Kathleen Taylor, Engagement and Participation Officer

What people told us and what we found

We heard that the ward had recently experienced a further Covid-19 outbreak, affecting staff and patients. This resulted in the ward being closed to admissions and visitors and the majority of activity provision being suspended for four weeks; however the situation has now resolved and normal activities are resuming in line with government guidance.

Care, treatment, support and participation

The ward has input from two consultant psychiatrists who cover the catchment area. There is also regular input from occupational therapy, physiotherapy and pharmacy. Input from other professionals, including dietetics and speech and language therapy, can be arranged on a referral basis. Social workers are involved on a case-by-case basis. Psychology input to the ward has been absent for some time, but has recently recommenced; the psychologist is currently providing stress and distress training for the nursing team as well as undertaking individual work with patients.

Multidisciplinary team (MDT) reviews and chronological notes are recorded on the EMIS electronic record keeping system. MDT decisions were clearly recorded. We heard that relatives are invited to attend reviews; until recently this was by conference call but face-to face meetings have recommenced. However we heard from one relative that they had experienced barriers to participation in meetings and poor communication with the medical and nursing team.

The majority of patients whose care we reviewed did not have a completed *Getting to Know Me* on file; where there was one the information it contained was very limited. This is a document which records a person's needs, likes and dislikes, personal preferences and background, aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. We could not find any life history information recorded within the files we reviewed. As most patients will move on to further care placements it is important that this information is recorded and goes with them through their care journey.

We reviewed the files of a number of patients who were prescribed as required medication for agitation, or were on enhanced levels of observation; however there were no care plans for the management of their stress and distress. The mental health care plan referred to the need to use distraction techniques, or use stress and distress management techniques, but there was no information on the specific triggers or de-escalation techniques for the individual patient.

The mental health care plans attempted to cover too broad a range of needs and issues in one plan. As a result, these lacked focus and did not contain sufficient information about the needs, treatment goals and interventions for the individual patient.

There was evidence of regular reviews of risk assessments and care plans; however, the care plan was not updated to reflect the outcome of the review. As a result care plans were missing important information gathered since admission and did not reflect patients current care needs and interventions.

Recommendation 1:

Managers should audit to ensure that *Getting To Know Me* documentation is fully completed and life history information is recorded and follows the patient when they move to a further care placement.

Recommendation 2:

Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.

Recommendation 3:

Managers should review their audit processes to improve the quality of mental health care plans to reflect the holistic care needs of each patient, and identify current interventions and care goals.

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

Use of mental health and incapacity legislation

Where an individual lacks capacity in relation to decisions about medical treatment, under s47 of the AWI Act, a certificate must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found that one s47 certificate had expired and asked that this be brought to the attention of the consultant.

We looked at a number of files of individuals who had a power of attorney (POA) or a guardian in place. All the files we reviewed contained a copy of the powers. However, we did find two s47 certificates which did not record that the proxy decision maker had been consulted.

Where patients were subject to detention under the Mental Health Act, copies of the detention paperwork were on file.

Recommendation 4:

Managers should audit to ensure that where an individual lacks capacity there is a valid s47 certificate in place to authorise treatment.

Recommendation 5:

Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted in relation to s47 certificate; the manager must ensure that this process and outcome is clearly recorded.

Rights and restrictions

We previously made a recommendation in relation to the locked door and information on how to exit the ward. This has been addressed; there is a locked door policy and information on this is located beside the exit.

Visiting is taking place in line with current guidance, with visits being booked in advance and each patient being able to have two visitors per day. The ward is providing flexible visiting times and is able to accommodate all current visit requests.

Time out and home visits to support discharge planning are facilitated with plans in place to ensure compliance with current restrictions and to minimise risk.

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 ward has sessional input from an occupational therapist, an occupational therapy assistant, and a patient activity co-ordinator. Between the three posts the ward has dedicated activity input Monday to Friday.

We heard that activity provision had been suspended for approximately four weeks during July due to a Covid-19 outbreak in the ward, but this has recently recommenced. We were advised that the occupational therapy department in the Argyle Unit, including the therapy kitchen, can now be accessed to provide patient activity, increasing the scope for group activities. We also heard that the activity co-ordinator organises outings on a Friday, using the hospital minibus. During our visit we saw individuals participating in gardening activities.

There is an activity board in each unit showing the activity programme for the week. However we did not find individual activity care plans providing information on individual's preferences and interests in the files we reviewed. We found evidence of activity participation and outcome recorded by the occupational therapist.

A Physiotherapy led exercise programme has been implemented in order to increase physical activity as well as aim to improve strength, balance and flexibility. The class, which is scheduled to run weekly is assisted by the Patient Activity Coordinator staff or Occupational Therapy Assistants. A maximum of four patients can attend a class due in order to adhere to social distancing guidelines and classes can vary from one-to-one sessions to a small group based on engagement from patients within the ward. Patients are asked for input into the type of music they would like to listen to within each class and advice on increasing or decreasing levels of difficulty are addressed and monitored throughout in order to tailor the class to each individual's needs and preferences. There can been some impact on delivering sessions dependant on leave and availability of staff to assist.

Recommendation 6:

Managers should ensure that patients have activity care plans which are person-centred, reflecting the individual's preferences (alongside activities specific to their care needs).

The physical environment

We previously made a recommendation in relation to a lack of storage facilities and the impact of this on the ward environment. On this visit we found the situation much improved; we heard that the equipment requirements had been reviewed and additional storage had been allocated elsewhere, reducing the need to store equipment within the ward. The ward was clean, bright and felt calm and welcoming. However we were told by the SCN that there are plans to redecorate much of the ward. We look forward to seeing these improvements on our next visit.

Summary of recommendations

1. Managers should audit to ensure that *Getting To Know Me* documentation is fully completed and life history information is recorded and follows the patient when they move to a further care placement.

2. Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.

3. Managers should review their audit processes to improve the quality of mental health care plans to reflect the holistic care needs of each patient, and identify current interventions and care goals.

4. Managers should audit to ensure that where an individual lacks capacity there is a valid s47 certificate in place to authorise treatment.

5. Managers should ensure that where a proxy has powers to consent to medical treatment this person must be consulted in relation to s47 certificate; the manager must ensure that this process and outcome is clearly recorded.

6. Managers should ensure that patients have activity care plans which are person-centred, reflecting the individual's preferences (alongside activities specific to their care needs).

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.

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