Mental Welfare Commission for Scotland

Report on announced visit to: North Ward, Dykebar Hospital, Grahamston Road Paisley, PA2 7DE

Date of visit: 10 November 2021

Where we visited

Due to the Covid-19 pandemic, the Commission 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 able to conduct our face to face visits, however, the reinstatement of lockdown required us to review this, and we are presently undertaking a variety of face-to-face and/or virtual visits. This local visit was able to be carried out face-to-face.

North Ward provides care for men over 65 years of age who require ongoing hospital care due to their complex mental health needs. The ward has 21 beds, all in en-suite bedrooms. On the day of our visit there were 18 patients. We last visited this service on 7 May 2019 and recommendations in relation to care plans and record keeping, proxy decision makers, covert medication and the provision of activities.

On the day of this visit we wanted to follow up on the previous recommendations and also look at visiting arrangements, and the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Who we met with

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

We spoke with the senior charge nurse.

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

We spoke with nine relatives, all of whom were complimentary about staff. They told us they were confident that their loved one was receiving good care and staff were friendly and approachable. We heard that they were patient and spent time chatting and knew their patients well. The relatives we spoke to told us they were consulted by staff in relation to treatment decisions and contacted if there were any concerns.

Care, treatment, support and participation

The ward has medical input from a consultant psychiatrist and a specialty doctor. There is dedicated occupational therapy (OT) and an OT technician, pharmacy and physiotherapy input; however due to vacancies, the physiotherapy input has been reduced significantly over recent months. The ward previously had dedicated psychology input. However, the psychologist moved post some months ago and has not been replaced. Given the complex needs of the patient group this is very much missed. Social work are involved on a case-by-case basis. Input from speech and language therapy, dietician, and other allied health professionals and specialist services, is available by referral.

Multidisciplinary (MDT) reviews are recorded on the EMIS electronic record keeping system, MDT notes provided a summary of recent presentation and care needs. Decisions and action required were clearly recorded, and this information is reflected in care plan evaluations. The requirement for NHS hospital care is reviewed on a regular basis. The views of proxy decision makers and families are recorded, and we heard that proxies are being invited to attend reviews, or, if this is not possible, are being consulted.

We found life history information and completed 'getting to know me' forms in the patients' files we reviewed. This is a document which contains information on an individual's needs, likes and dislikes, personal preferences and background, which enables staff to understand what is important to the individual and how best to provide person-centred care whilst they are in hospital. This, and other information gathered, is used to populate 'what matters to me' which is available within patients' bedrooms as an aide memoire to staff.

Within the care plans we reviewed, risk assessments were documented and reviewed regularly. Care plans were person-centred and addressed identified risk and current needs as well as providing relevant information about recent changes. There is a holistic approach to care, with good integration of information from all sources. Care plan evaluations were regular, thoughtful and meaningful, and care plans were updated to incorporate changes in risk, decisions from MDT reviews, and the care plan evaluation information.

Where an individual was experiencing stress and distress, there was a detailed care plan which included information on the potential triggers, behaviours exhibited and management strategies, which have been found to be effective for the individual; the majority of these followed the Newcastle model. This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. The model emphasises the use of sharing information with staff to develop effective care plans.

In the notes we reviewed we found detailed physical health care plans and physical health care needs were being addressed with patients being referred for specialist review or follow up when required.

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 staffing arrangements to ensure that patients have access to the full range of professionals required to meet their needs.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health Act, copies of detention paperwork were on file.

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 (T2/3) under the Mental Health Act were in place where required, and authorised all treatment prescribed.

Where patients had a proxy decision-maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), this was recorded in the care file and in all the files we reviewed the certificate granting the power of attorney (POA) was on file; however, in two files, the detail of the powers granted was not attached.

Where individuals lacked capacity to make decisions about their health care, section 47 certificates, which authorise treatment under the AWI Act, were in place and proxy decision makers were being consulted in relation to treatment.

Recommendation 2:

Managers should undertake an audit to ensure the powers granted to proxy-decision makers are held on file.

Rights and restrictions

The ward door is secured using a keypad entry system, there is a locked door policy. We saw information on advocacy services on display within the ward and were advised that one patient is currently receiving advocacy support.

We heard that the previous visiting restrictions, in place due to the pandemic, did impact on the frequency of visits for patients. However, the ward can now accommodate 15 visits per day, which can be booked in advance. Visiting is possible from morning through till evening and it is now possible to accommodate all the visit requests they are receiving.

Patients can be taken out by their visitors if they wish.

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

There is a health care support worker dedicated to activity provision. The ward activity board included a wide range of activities including breakfast and lunch groups, reminiscence work, football memories groups, music sessions, virtual therapet sessions, life history work, games etc. There was information about playlists for life on display and we heard that a number of staff had undertaken training in this. There is a football memories box containing football memorabilia and items which can be used for reminiscence work. Within care files we found good information on previous occupation, hobbies and interests, including musical preferences, and this was reflected in their activity care plan. We found regular recording of activity preference and participation within chronological notes.

The physical environment

The ward comprises of 21 single en-suite bedrooms. We noted a good level of personalisation within bedrooms with family picture and personal items on display. There is dementia friendly signage throughout the ward. There is a small quiet sitting room and an activity room, both with direct access to a pleasant level garden area with covered seating. The activity room has been thoughtfully decorated with a bar/pub area and football memorabilia on display, this room is well used for breakfast and lunch groups and various group and individual activities. On the corridors there are a number of activity boards and pictures of sporting celebrities and local scenes. The main sitting area sits at the crossroads of the corridors in the central hub of the ward, with a number of bedrooms off this area. As a result this is a busy thoroughfare. Natural light is provided by a skylight however, there are no windows in this area. This area is a gloomy and uninviting space for patients, some of whom spend a considerable amount of their day here and is not fit for purpose.

Recommendation 3:

Managers should undertake a main sitting area environmental audit and develop an action plan to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group.

Any other comments

We heard from a number of relatives that clothing supplied had gone missing, either when sent for marking or laundering. They had been offered compensation to enable them to replace the missing items.

Recommendation 4:

Managers should undertake a review of the current system for managing laundry.

Summary of recommendations

1. Managers should review staffing arrangements to ensure that patients have access to the full range of professionals required to meet their needs.

2. Managers should undertake an audit to ensure the powers granted to proxy decision makers are held on file.

3. Managers should undertake a main sitting area environmental audit and develop an action plan to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group.

4. Managers should undertake a review of the current system for managing laundry.

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.

SUZANNE MCGUINNESS
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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