Mental Welfare Commission for Scotland

Report on announced visit to: Willow Ward, Orchard View, Inverclyde Royal Hospital, Larkfield Road, Greenock PA16 OPG

Date of visit: 14 December 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Willow Ward is a 30-bedded unit providing care for older adults with complex care needs. The ward is housed within a purpose built unit and is bright and spacious, with 30 single en-suite bedrooms, several sitting rooms and access to pleasant enclosed gardens. On the day of our visit there were 22 patients. We last visited this service on 6 February 2020 and made recommendations in relation to care plans, proxy decision makers and the locked door policy.

On the day of this visit we wanted to follow up on our previous recommendations and look at activity provision. This is because of the impact of the pandemic on service delivery.

Who we met with

We met with and/or reviewed the care and treatment of nine patients and spoke with one relative.

We spoke with the senior charge nurse (SCN), charge nurse, occupational therapists (OT), patient activity co-ordinator and medical fellow.

In addition we met with the service manager.

Commission visitors

Mary Hattie, Nursing Officer

Margo Fyfe, Senior Manager (Practitioners)

Kathleen Taylor, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

The ward has one consultant psychiatrist who visits the ward weekly for multidisciplinary team (MDT) meetings. There is a visiting GP twice per week and a clinical fellow who provides additional medical cover during office hours; outwith this, medical cover is provided by the hospital duty doctor rota. There is good input from allied health professionals (AHP), with dedicated input from psychology, OT, physiotherapy and pharmacy with other services being available on a referral basis.

MDT reviews are recorded on the EMIS electronic record keeping system. MDT notes provided a summary of recent presentation and care needs, however these were brief, and lacking in detail on decisions taken and follow up action required. Individual case reviews are again being carried out on a three monthly basis, which includes reviewing the requirement for NHS hospital care. We heard that proxy decision makers are being invited to attend reviews, or if this is not possible, are being consulted.

We found detailed plans for the management of individuals who experience stress and distress. The plans included information on the potential triggers, behaviours exhibited and management strategies which have been found to be effective for the individual, using 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 behaviours that challenge.

We found that the care plans we reviewed were person-centred and addressed all the identified needs and risks for the patients. Care plans were reviewed regularly, with the majority of reviews containing a good level of meaningful information, however this was not consistent with a number of plans which we found lacked detail. In two of the files we reviewed we found that the care plan had not been updated to reflect a change in the patient's current legal status.

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 MDT notes contain information on decisions taken and actions required.

Recommendation 2:

Managers should audit care plans to ensure all individual plans reflect current needs and reviews are meaningful.

Use of mental health and incapacity legislation

Where individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), the detention paperwork was 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. Patients receiving treatment under the Mental Health Act had T3 or T2 certificates in place authorising their treatment.

Where individuals have granted a Power of Attorney (POA) or guardianship under the Adults with Incapacity (Scotland) 2000 Act (the AWI Act), a copy of the powers granted should be held in the patients care file and the proxy decision maker should be consulted appropriately. We found where there is a proxy, this was recorded in the care files we reviewed. There was evidence that they were being consulted, however we could not find copies of the powers in some of the files.

Section 47 of the AWI Act authorises medical treatment for people who are unable to give consent. Under s47 authorisation, a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity. We found s47 certificates in all the files we reviewed.

Recommendation 3:

Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are on file.

Rights and restrictions

The ward door is secured and access is controlled by nursing staff, for reasons of patient safety. At the time of our last visit we made recommendations regarding this situation. On this visit we were pleased to see the ward has a locked door policy and there was information on display telling patients or visitors how to access or exit the ward.

The ward has until recently been working with a booked visiting system, in line with the covid restrictions which were in place. The ward has now returned to open visiting in line with current Covid-19 guidance. Whilst restrictions were in place, staff proactively contacted relatives and facilitated virtual visits using a variety of platforms. The ward has not experienced any difficulties in accommodating visitors.

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 a dedicated patient activity co-ordinator who provides a wide range of activities on an individual and small group basis. This includes a wide range of activities, including

lunchtime social groups, men's evening group, reminiscence work, music sessions, life history work, chair exercises, hand massage, gardening, football, mini golf and bowls games in the courtyard or simply going for a walk and chatting.

There is also a full time occupational therapist and occupational therapy assistant, who also provide a range of therapeutic activities, which includes craft based activities, breakfast and lunch groups, life story work and playlists for life, as well as assessments of patients. The occupational therapy staff and activity nurse co-ordinate their programmes to maximise availability of activities for all patients. The ward has access to a minibus, however due to current restrictions outings are on an individual basis only. We heard from the activity nurse about the plans for local reminiscence outings once Covid-19 regulations allow for group trips.

During our visit we saw a number of staff engaging with patients in a range of activities, or simply spending time chatting with them.

We were told that the activity co-ordinator post is currently funded on a fixed term basis, however it is hoped that this valuable resource can be made permanent.

The physical environment

The ward is clean and bright and benefits from access to enclosed courtyard gardens which can be accessed from the main sitting area, and pleasant landscaped space around the building. There are also a number of smaller sitting rooms which were being used during our visit. We heard that there are plans to develop a multisensory room in one of the smaller sitting areas which is less frequently used, with some equipment already in place. The ward had a calm peaceful atmosphere. There are pictures of local places of interest on the corridor walls and dementia-friendly signage throughout. Orientation is supported by the use of patients' names and memory boxes outside bedrooms and the use of different colours in different parts of the ward.

The Orchard Unit previously had a café in the foyer which was well used by patients and visitors, however this closed at the beginning of the pandemic. It was open briefly when restrictions began to ease, however the provider withdrew and it currently remains closed. We heard from staff and a relative that this facility was greatly valued and is very much missed.

Summary of recommendations

1. Managers should audit care plans to ensure these reflect current needs and reviews are meaningful.
2. Managers should ensure MDT notes contain information on decisions taken and actions required.
3. Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are on file.

Good practice

We saw a number of life story books which have been developed by the patient activity co-ordinator and occupational therapy staff in collaboration with the patients and their families. These were hard backed albums which contained information about the individual's family, school and work life and interests. These were illustrated by pictures of significant events and places in the patient's life, accompanied by a narrative, where possible in the patient's own words. We heard how relatives and staff used these to stimulate conversation and reminisce with the patients, and that these go with the patient when they transfer to other settings, providing valuable information about the person for their care team.

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 Commission 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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