Mental Welfare Commission for Scotland

Report on announced visit to: Glencairn Ward, Midpark Hospital, Bankend Road, Dumfries DG1 4TN

Date of visit: 10 February 2022

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.

We visited Glencairn Ward in Midpark Hospital, Dumfries. We last visited this resource in December 2017 and in the intervening period, Glencairn Ward has undergone a number of significant changes. During our 2017 visit, the ward provided an intermediate care facility for patients with complex needs who were awaiting a community placement.

In April 2020, the ward was closed and staff and patients were moved to other clinical areas within Midpark. This was necessary to accommodate the relocation of the palliative care unit from Dumfries and Galloway Royal Infirmary and support acute services to manage the surge in demand as a result of the global pandemic.

Glencairn Ward resumed as an intermediate care ward until April 2021, when the ward remit again changed to an older adult acute admission facility as part of an overall reconfiguration of Midpark beds. This brought together patients and staff from both the 'old' and the 'new' service; and required focussed management to establish a cohesive team delivering a revised service in line with their new remit. During this visit, we wanted to see how this transition was progressing and hear from patients about the impact of this redesigned service on the care and treatment they were receiving.

On our last visit, we made four recommendations in relation to care plans, recording, ensuring patients' legal status was clear and training for staff in the Adults with Incapacity (Scotland) Act 2003 ('the AWI Act') and consent to treatment under this legislation. Although the remit of the ward has changed, these recommendations remain relevant and we wanted to see what progress had been made in these specific areas.

Who we met with

On the day of our visit, there were 14 patients on the ward. We met with and/or reviewed the care and treatment of seven patients. Due to Covid-19 imposed restrictions we did not have the opportunity to meet with family/carers as we normally would; we offered times for telephone consultation instead, however, we did not receive any requests for this involvement.

We took the opportunity to meet with a range of staff involved in the delivery of the service, which included consultant psychiatrists, nursing staff, occupational therapy service manager, consultant clinical psychologist, advocacy and a ward volunteer, in addition to the relevant managers for the service.

Commission visitors

Yvonne Bennett, Social Work Officer

Margo Fyfe, Senior Manager (Practitioners) West Team

What people told us and what we found

The patients we spoke to on the day of our visit all spoke very highly about the care and treatment they received within the service. They found the ward environment to be pleasant, caring and therapeutic and reported that staff were supportive, accessible and approachable across the board. We saw evidence of what patients described throughout the day.

Care, treatment, support and participation

We heard that considerable activity had taken place to establish a ward "ethos", particularly in light of the amalgamation of a range of staff, some of whom had not previously practised with this patient population nor worked together before. Work had been led by clinical psychology to adopt and embed a pro-social model, which helped the team formation and identification of core values and the direction the service wanted to go within this new service model.

We saw staff engaging with patients throughout the day providing one-to-one clinical interventions as well as opportunities for both therapeutic and social interactions. There was an energy within the ward which was positive and encouraged participation from the wider multidisciplinary team (MDT) and our observation of this was shared and confirmed by the patients and the range of staff we met during the visit.

We heard about the holistic approach to mental health and wellbeing, which underpins the care and treatment being delivered on the ward, and the encouragement patients received to participate in this approach, wherever possible. We spoke to Dumfries and Galloway advocacy service during the visit who confirmed this from their involvement.

Against the backdrop of this positive and progressive service delivery we witnessed and heard about, we were disappointed not to see this adequately reflected in records. We have previously highlighted recording styles and processes as an area for improvement across the service. Despite a range of improvement action plans being in place, we could see very little progress in ensuring recording was of an acceptable standard. Care plans remain basic and not person-centred and reviews appeared perfunctory. We found that care plans were not updated in light of the outcome of the review. These issues were disappointing given the high quality of the service delivery we saw and heard about.

Recording of MDT discussion and decisions also required improvement. Templates have been provided for this important record which should inform care plans and interventions in light of the individual's progress. However we found that these were, at times, partially completed or referred to notes recorded in other parts of the electronic system. This approach required staff to access different electronic platforms to view the detail of the MDT decisions.

We found that daily notes were minimal and recorded in the SBAR format (Situation, Background, Assessment and Recommendation). The SBAR format does not lend itself appropriately to the purpose of recording daily progress for patients. This has been highlighted in previous visits and again we were aware of improvement activities to address this but this has not yet translated into practice.

Overall the use of a range of electronic platforms within the service continues to be complicated to navigate and does not support accessible, key information sharing. In a bid to address some of these deficits, a paperlite folder is retained which contains key information, including legal status but we found this was not up to date for some individual's records. This may be as a result of staff having to access the various electronic platforms to input information throughout their shift as well as maintain the paper file. However, the outcome continues to be a degree of confusion around appropriate recording formats which requires urgent action.

There is a long standing recognition that the electronic system requires to be updated and that this improvement has taken a back seat during the pandemic – this remains a long term solution. In the interim, managers require to address the quality of care planning, recording of MDT meetings and decisions ensuring key information, e.g., legal status and risk assessment, is accurate and accessible to staff delivering care.

We have discussed this with the service manager and will follow up issues with senior management.

Recommendation 1:

Managers must address the quality of recording as a matter of urgency. Care plans, MDT records, risk assessments, daily notes and legal status should be fully recorded and accessible within one electronic record.

Use of mental health and incapacity legislation

We reviewed the legal authority for ongoing care and treatment for patients within this service and found all the required statutory paperwork to be in place.

We looked at consent to treatment certificates (T2) and certificates authorising treatment (T3) for all patients who required these and found them to be current and relevant.

For some patients who lacked capacity to consent to medical treatment, their care was authorised by a section 47 certificate under the AWI Act. We found that this is often referred to as the patient being "under AWI". This terminology can give rise to some confusion in relation to what legal authority is in place for an individual patient. Being subject to AWI could mean that there is a power of attorney (POA) or that a welfare guardian has been appointed. We would urge services to be specific about what part of "AWI" is in place and be specific around which AWI Act measures relate to individuals to ensure there is clarity around existing legal authority for individual patients. We look forward to seeing improvement in this area during our next visit.

In October 2021, the Mental Welfare Commission published an advice note entitled *The scope and limitations of the use of section 47 of the Adults with Incapacity Act*. This is a useful practice guide which will support a more accurate use of terminology to avoid confusion: https://www.mwcscot.org.uk/node/1638

Rights and restrictions

We met with representatives from the local advocacy project who advised that they are in the hospital on a twice weekly basis. We heard that advocacy are flexible in terms of offering appointments to meet patients to discuss their rights and support them to express their views. This can take place in the formal setting of a Mental Health Tribunal, less formally with the MDT or raising any specific issues they may have directly with the service.

Sections 281 to 286 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections and where restrictions have been introduced, it is important that the principle of least restriction is applied. During this visit, we made enquiries about restrictions in relation to a patient and we will follow this up with the Responsible Medical Officer.

The Commission has published a *Use of seclusion* good practice guide which can be found at: https://www.mwcscot.org.uk/node/1243

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/rights-in-mind/

Activity and occupation

As with many of the services we have visited recently, the surge in clinical demand has resulted in a reduction in the capacity within the service to offer an optimum level of meaningful activity within busy wards. Glencairn is no exception, however we were able to see this beginning to recover and the focus on providing positive, meaningful activity returning. Within Glencairn Ward, activities are seen as everyone's responsibility with support and direction; and at times direct involvement from a range of allied health professionals and psychology. We heard of ambitious plans for the development of activities, including the resumption of community involvement and activity which will support continued recovery on discharge.

Group based interventions are being similarly refreshed with the resumption of a range of groups, including a 'Better Sleep' group, anxiety management, problem solving as well as mindfulness and relaxation. These groups are being offered as part of a collaborative approach between nursing, occupational therapy and psychological services and offer holistic, recovery based interventions, which all contribute to a supported and more sustainable discharge from hospital.

We heard about the involvement of a ward volunteer and had the opportunity to meet with them to discuss this role in more detail. This role has been developed over the last 18 months and the scope and parameters of the role have been considered and formalised to offer a degree of support and governance to both the individual and the service. The volunteer spends agreed times on the ward offering informal interaction with patients who have either

expressed a desire to become involved, or where there is a view that this would be a helpful addition to the existing service. We were told of a number of instances where this role has brought an additional support to individual patients, offering time and interaction outwith, but complementary to, the professional intervention. This is a role which is valued by patients and staff within the service and has potential to be expanded across other wards supported by the framework and experience to date. We look forward to seeing how this develops.

The physical environment

Glencairn Ward offers a pleasant and homely environment for patients. Since the reconfiguration of the ward there has been significant activity to consider how to maximise this, including a project with a local camera club which has received positive feedback from patients.

The ward continues to operate on the basis of 13 beds with two additional beds being designated as surge beds; with a further one exceptional surge space to accommodate potential increased demand as a result of the ongoing management of Covid-19.

The surge spaces reduce the space available within the ward and this is further reduced by the use of one of the activity rooms to accommodate computers for use by nursing staff. With the resumption and further development of activities, these additional spaces could enhance options for use by patients and we would ask managers to reconsider these spaces as soon as practicable. We heard from nursing staff that time spent within this room at a computer is time spent away from patients and the reinstatement of the nursing station within the ward was viewed as a more practical and functional use of space. The service manager has made a formal request to managers to consider this.

Good practice

During our visit to Glencairn Ward, we saw significant changes to how the service is delivered, most notably the involvement of the full range of the multidisciplinary team in the day-to-day service development. Establishing this service, particularly during the pandemic, has been a significant task and we saw how these changes have been achieved as a result of strong and exemplary leadership from the senior charge nurse.

Summary of Recommendations

1. Managers must address the quality of recording as a matter of urgency. Care plans, MDT records, risk assessments, daily notes and legal status should be fully recorded and accessible within one electronic record.

Service response to recommendations

The Commission requires a response to this recommendation 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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Mental Welfare Commission 2022