mental welfare
commission for scotland

Mental Welfare Commission for Scotland

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

Date of visit: 26 April 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 Cree Ward in Midpark Hospital, Dumfries. We last visited this resource in December 2017. This visit has been delayed as a result of Covid-19 restrictions and more recently outbreaks of Covid-19 within the ward.

Cree Ward is a 16-bedded specialist inpatient acute assessment ward for people with actual or suspected cognitive impairment as a result of dementia. Patients who are admitted to Cree Ward are acutely unwell, and experiencing acute stress and distress associated with a deterioration in their cognitive abilities, or are in crisis as a result of their cognitive impairment. Admission to Cree Ward is required when care and treatment options are beyond the intensive support available in the community, where the person has either not responded to treatment or have raised levels of risk as a result of their presentation.

The ward supports patients for all localities within Dumfries and Galloway for inpatient assessment and treatment.

Who we met with

On the day of our visit, there were 14 patients in the service. We met with and/or reviewed the care and treatment of seven patients. We also met with four relatives who were visiting the ward on the day of our visit.

We also had an opportunity to speak with a range of staff who contribute to the care team – nursing staff, both of the consultant psychiatrists who cover the ward, clinical psychologist and the occupational therapy service manager. This provided a good overview of service delivery within the ward.

Commission visitors

Yvonne Bennett, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

The patients we met during the visit struggled to offer verbal feedback on how they felt about the care and support they were receiving, which was due to the level of cognitive impairment they were experiencing. However, throughout the day we were able to observe a calm environment, with patients engaging with a range of staff in a warm and supportive manner. There was clear evidence of positive therapeutic relationships, which offered support, reassurance and diversion from stress and distressed behaviours.

This positive impression was reinforced by feedback from the relatives we met with. All of whom spoke very highly of the support, care and treatment their relative was receiving on the ward. In addition, we heard that this was supplemented by a high degree of support they received as family carers, which supports them to understand and manage their loved one's diagnosis and presentation. All of the relatives we met told us that this support was invaluable for them and they appreciated the time and compassion shown to them by staff, often against a backdrop of high clinical demand for the staff group. They reported that staff were accessible and available to provide information or support whenever required and they felt reassured that they were leaving their relative in "good hands".

Care, treatment, support and participation

Having spoken with patients and relatives, we then reviewed records of care within the ward. We found care plans had improved since our last visit. We saw evidence of a more person centred and strengths based approach and noted ongoing developments in ensuring this approach was embedded across the service. We saw further developments of the care plans being recorded in an electronic format, which focussed on patient's goals and the support needed to work towards these. We look forward to seeing how these care plans continue to be developed on our next visit.

We also looked at reviews of care plans and felt that these could be more comprehensive and take account of changes in the patients' presentation and the impact of the nursing interventions. This is already recognised within the service and work is ongoing to improve the quality and consistency of the review process.

We saw evidence of the use of the 'Getting to Know Me' documentation which provides a rich source of information about a patient which they may not be able to share themselves and which may offer insight into what is important to them as an individual.

The ward use the Newcastle Model - a non-pharmacological approach that offers an alternative to medication in the management of behaviours which might challenge care givers. This approach views behaviours which challenge others as a consequence of an unmet need; this approach seeks to identify the root causes of the presentation to establish a consistent and person centred response, which manages and potentially reduces the stress and distress and resulting behaviour. This is an important intervention within this setting – a large proportion of patients from Cree Ward are discharged to nursing homes in the community and the success of this discharge can be enhanced by having established these responses and the continuity of approach within the new placement.

Patient involvement in care plans was difficult due to the severity of cognitive impairment, however we were pleased to see family/carer involvement instead, with care plans signed off by relatives, where appropriate. Overall, we saw good evidence of the implementation of the Triangle of Care, a model of working collaboration between the patient, professional and carer that promotes safety, supports recovery and sustains well- being. While we heard that normal visiting arrangements, which had been restricted during Covid-19, have resumed, we also heard of creative ways of supporting contact with family, which had been implemented during the restrictions, in light of the importance of this contact for individual patients.

There was evidence of regular multidisciplinary meetings (MDT's) with attendance from the full multi-disciplinary team, depending on the needs of the individual patient. We noted the absence of access to speech and language therapy within this forum; we observed this as a gap in a service where communication was often problematic for the patient group.

We saw an improvement in the recording of MDT meetings and plans to develop this further with the roll out of an accessible electronic version of the MDT record. We welcome the consistency this should offer and look forward to seeing this development on our next visit.

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 this and they were all in place and current.

We discussed the use of 'as required' medication, which we noted was used regularly for some patients. The use of this 'as required' medication is recorded within patient records but we felt that this could be more robustly reviewed to consider if this treatment should be prescribed routinely, rather than continued on an 'as required' basis. The senior charge nurse has agreed to consider how this could be reviewed on a regular basis and fed into the MDT process.

For some patients who lacked capacity to consent to medical treatment, their care was authorised by a section 47 certificate under Adults with Incapacity (Scotland) Act 2000 (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 or that a welfare guardian has been appointed; we would urge services to be specific about what part of "AWI" is in place to ensure there is clarity around existing legal authority for individual patients. We would urge services to be specific about what AWIA measure a patient is subject to.

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. This can be found at: https://www.mwcscot.org.uk/sites/default/files/2021-10/Scope-Limitations-S47_advice2021.pdf

We look forward to observing a more accurate use of AWIA terminology at our next visit.

Within patient records we saw a number of DNACPR certificates which had been signed off without a record of consultation with proxy decision makers – welfare guardians or powers of attorney. We noted that these certificates had at times been signed off prior to the patient being admitted to Cree Ward. We would expect that this should be discussed with the proxy decision maker to ensure they are aware and in agreement with this decision. We discussed this on the day of our visit and are assured that this will be followed up by the senior charge nurse.

Rights and restrictions

Due to the complex needs of the patients, Cree Ward operates a locked door policy and we were satisfied that this restriction was commensurate with the needs of the patients.

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

During the visit we saw patients engaging in individual activities throughout the day and we heard that activity levels were the focus of post Covid-19 recovery within the ward. We heard of plans to revamp the garden area as part of a therapeutic activity with patients being involved in the planning and implementation activity as much as possible. This will offer meaningful activity and improve the outside space available for the patients to use.

We heard that Occupational Therapy (OT) input has been limited due to vacancies within this professional group but that recruitment to these posts is ongoing and that currently there is OT involvement on Cree Ward which is leading on the gardening project.

Links with the community have been limited during Covid-19 restrictions but there are signs of recovery in this area and following the success of a volunteering project in the adjoining ward, there are plans to consider extending this into Cree Ward.

The ward has access to a Tovertafel or a 'Magic Table' an interactive light game for people with mid to late stage dementia, designed to stimulate activity – physical, mental and social and can offer diversion from stress and distressed behaviour. We heard mixed reviews about this resource from patients but staff reported that for some patients this offered opportunities to deescalate stressed behaviour and stimulated interaction for others who presented as withdrawn and isolated.

The physical environment

Cree Ward offers a pleasant environment with patients accommodated in single rooms with en-suite facilities and access to communal areas which are well maintained.

Patients have access to an enclosed garden area which is in the process of being remodelled to offer a more pleasant outside space.

Good practice

Cree Ward offers a good example of the importance and the benefit of the Triangle of Care model. The commitment to this model of intervention is clear and shared across the whole staff group and the feedback from carers/relatives reflected this. There was a sense from the carers we spoke with that they not only felt integral to their relatives care on the ward but that they too derived care and support from this approach which made their experience as a carer more manageable.

Other issues

During the visit we heard how access and availability of community supports was adversely impacting on discharge planning for patients within the service. Whilst this is not just a local issue we heard how the lack of availability of support staff locally meant that patients who were deemed ready for discharge were required to remain in hospital longer that was deemed necessary. This is a national picture but we will follow this up with the local Health and Social Care Partnership for further information about the extent of this issue and local plans to mitigate delaying discharges wherever possible.

Service response to recommendations

There were no recommendations for the service to respond to in 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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