Mental Welfare Commission for Scotland

Report on announced visit to: The Prosen Unit, Whitehills Health and Community Care Centre, Station Road, Forfar, DD8 3DY

Date of visit: 31 March 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 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, we are therefore undertaking a mix of virtual and face-to-face visits. This local visit was carried out face-to-face.

Prosen Unit located at Whitehills Health and Community Centre in a community hospital. The unit is a 10-bedded, mixed-sex ward which are all single en-suite rooms. The unit provides admission, assessment, and treatment for people with dementia. On the day of our visit there were three vacant beds.

We last visited this service on 8 May 2019 and made no recommendations.

On the day of this visit we wanted to hear how patients and staff have managed throughout the current pandemic. We also wanted to look generally at the care and support being provided in the unit because it has been over two years since our previous visit.

Who we met with

We met with and reviewed the care and treatment of four patients and received a letter from one carer.

We spoke with the lead nurse, senior charge nurse and charge nurse.

Commission visitors

Alyson Paterson, Social Work Officer

Gillian Gibson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with during our visit spoke highly of the staff on the ward describing them as “wonderful” and “kind”. The relative who wrote to us talked of staff being “caring’, “professional”, having a “cheerful attitude” and being a “credit to the NHS”. During our visit the ward appeared calm and we witnessed staff spending time with patients on a one-to-one basis. The food on the ward was described by one patient as the best they had ever had and we understand that all of the food is freshly prepared on site.

However, we also heard from those that we spoke with, about the lack of meaningful activity. One patient talked of being very bored, despite having had a range of interests prior to being admitted to the ward. Another patient spoke of getting a bed, meals and medication, and feeling bored with nothing to do apart from sleep and eat. During our visit we saw a group of patients in the sitting room who were not engaged in any organised activity.

One patient told us that they had not had the opportunity to meet their doctor. The patient told us that information is passed between patients and doctors via the nurses. We were advised by nursing staff that there is a weekly multi-disciplinary team (MDT) meeting and that patients can attend if they choose to.

During our visit we reviewed patients’ electronic files. We were pleased to see a number of care plans on file which were detailed and covered a range of physical wellbeing and mental health needs including discharge planning. Also included was a ‘Getting to know me’ document which was very detailed. Care plans showed evidence of agreed goals and interventions along with barriers to engagement. We saw evidence that these plans were regularly reviewed. We were pleased to see that family were involved, where appropriate, in care planning and decision making. We were disappointed, however, that some documentation in electronic files had not been completed and was left blank.

To record the outcome of MDT meetings, a document entitled SCAMPER is held in patients’ electronic records. From the files we reviewed, it appeared that SCAMPER was only completed by nursing staff rather that the wider MDT. There is a part on the form for the MDT to complete pre-meeting, which all disciplines should contribute to. It would be helpful to have all members of the MDT complete SCAMPER, whether they attend the MDT meeting or not. We were told that MDT meetings are held via Microsoft Teams (MST) and that the form remains on MST until it is uploaded. We were unable to locate the most recent MDT meeting form as it had not been uploaded, and suggest that these are uploaded in a timely manner. It was not always clear which members of the MDT attended the meeting and we would welcome this being recorded.

To support ongoing quality of care plans and documentation, there are regular audits undertaken by the nursing team. This is a peer-led model and is undertaken on a monthly basis.

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

On the day of our visit we were told that 50% of the patients are delayed discharge. This means that they remain in hospital despite being clinically fit for discharge. The reasons for these delays included: difficulty in sourcing care home placements, difficulty in sourcing packages of care in order to return home, and waiting for guardianship orders to be granted to facilitate discharge. We heard from one patient that they were due to be discharged home however there was no occupational therapy (OT) support available to facilitate a home visit/home assessment. This left the patient feeling worried about his ability to return home. Another patient told us that they did not understand why a care home had not been found for them. Nursing staff advised us that the patient's social worker was off sick and the case had not been reallocated.

The Commission is of the view that discharge planning should begin on admission, however we heard that the reality is that social work/mental health officer (MHO) referrals will only be accepted once an individual is deemed fit for discharge. We heard that allocation of an MHO takes on average three months. We believe that this can lead to individuals being inappropriately and unnecessarily delayed in hospital.

Recommendation 1:

Managers should develop a more responsive and timely referral process in conjunction with the social work managers.

Multidisciplinary team (MDT)

We saw that there was input on the ward from a range of professionals; this includes a dedicated psychiatrist for the ward, a full time pharmacist, a psychologist and a part-time occupational therapist (OT). The OT and psychologist work on a referral basis rather than providing input generally in the ward. The senior charge nurse for the ward is an advanced practitioner which means they are allowed to prescribe some medication.

We were advised that the psychologist for the ward had committed to completing stress and distress formulations for all new patients admitted to the ward. We heard that for those patients who have had a longer stay in hospital, even though they may experience high levels of stressed and distressed behaviours, there is not the same opportunity for this type of psychological formulation. We would welcome this being reviewed.

Use of mental health and incapacity legislation

On the day of our visit, we reviewed a number of patients' files. The paperwork relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 appeared in order and was accessible. This included consent to treatment certificates (T3) which were up-to-date.

For those patients lacking capacity and requiring a proxy decision maker, all paperwork relating to the Adults with Incapacity (Scotland) Act 2000 were available and accessible. We saw section 47 certificates on file (consent to treatment certificates for those who lack capacity) including treatment plans.

Rights and restrictions

The doors to the unit were locked on the day of our visit, however information about the locked door policy was clearly displayed as you enter the ward.

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

A part-time occupational therapist (OT) provides input into the ward on a referral only basis. Previously an OT assistant provided three sessions per week to patients on the ward which included facilitating group activities. Providing activities is now the responsibility of nursing staff and this important intervention is not always able to be prioritised. We are aware that nursing staff regularly engage with patients however this is not always recorded as an intervention or an activity. A major deficit on the ward is the provision of a dedicated activities co-ordinator to organise and facilitate meaningful activities. We recognise that nursing staff regularly interact and engage with patients in a less formal way and are providing a form of activity. On the day of our visit we spoke to the charge nurse on the ward about this issue and signposted them to an interests and activities toolkit which has been widely used and adopted in care settings. This can be can be used by all staff to identify patient's past, present and future interests to make activities and interactions more meaningful.

Recommendation 2:

Managers should ensure that activity participation is recorded and evaluated.

Recommendation 3:

Managers should ensure that there is a dedicated activities co-ordinator for the ward to ensure regular meaningful activities are on offer to all patients.

The physical environment

The ward is 10-bedded and all rooms are single and en-suite. The atmosphere on the ward on the day of our visit was calm. We were pleased to see that patients had easy access to a sheltered, secure and well maintained garden from the ward. However, we felt that the ward did not have a particularly homely feel to it; it was sparsely decorated with little colour, photographs or signage to orientate patients. We had the opportunity to see patients' bedrooms. Although all patients have their own en-suite room, we felt the rooms were sparse with limited information on the boards to orientate patients, for example, with named nurse and consultant details. One notice board in the ward corridor was cluttered and would have been better placed in the staff room.

Recommendation 4:

Managers should ensure that a dementia appropriate environment assessment be undertaken and the findings from this implemented.

Any other comments

We were pleased to hear about the good working relationship the ward has with the dementia liaison team. This team is involved in all aspects of discharge planning including pre-admission to a care home. The team will remain involved as long as necessary resulting in less failed placements and readmissions to hospital.

In discussion with staff, it was evident that there was an emphasis on staff training. We were pleased to hear that all staff attend two day 'Stress and Distress' training, which is facilitated by psychology staff. This supports staff to develop key skills, knowledge and competencies to engage in proactive approaches to understand distressed behaviour, prevent this from arising in a person living with dementia and intervene appropriately if they do. This also supports staff to engage in an individualised formulation driven approach with psychology staff, which aims to improve the experience, care, treatment and outcomes for people with dementia, their families and carers.

We were encouraged to hear that the service has introduced a neurological observation protocol in response to a previous incident on the ward. In order to proactively manage head injuries, all staff complete 'Glasgow Coma Scale' (GCS) training online annually. All patients have a GCS baseline taken on admission and for the following three days. A clear flow chart has been developed for the management of head injuries which clearly stipulates the actions and observations required from nursing and medical staff.

We heard from staff how difficult the last 18 months has been as a result of the pandemic. We were told of the challenges in terms of trying to keep patients safe whilst at the same time facilitating patient visits. We were impressed to hear how the team had pulled together during this difficult period including managing staff absences.

Summary of recommendations

1. Managers should develop a more responsive and timely referral process in conjunction with the social work managers.

2. Managers should ensure that activity participation is recorded and evaluated.

3. Managers should ensure that there is a dedicated activities co-ordinator for the ward to ensure regular meaningful activities are on offer to all patients.

4. Managers should ensure that a dementia appropriate environment assessment be undertaken and the findings from this implemented.

Service response to recommendations

The Commission requires a response to these recommendations in three months of receipt 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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