Mental Welfare Commission for Scotland

Report on an unannounced visit to: Arran Ward, Dykebar Hospital, Grahamston Road, Paisley, PA2 7DE

Date of visit: 25 May 2022

Where we visited

At the Commission, due to the Covid-19 pandemic, we have had to adapt our 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 able to be carried out face to face.

Arran Ward (formerly known as Arran and Bute Wards) in Dykebar Hospital is a 20-bedded inpatient mental health unit which functions as two separate services within the one ward. The ward provides eight rehabilitation beds and twelve recovery beds. The rehabilitation part of the service is viewed as short to medium stay with an expected admission time of up to two years. All the patients in this part of the service have single rooms. The recovery part of the service is for longer stay patients with an expected length of stay of up to five years. The accommodation for this part of the service is provided in dormitories and single rooms. Previously the ward was two separate wards but this was converted to a single ward for the purposes of creating a combined rehabilitation and recovery model. The ward has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, pharmacy staff and psychology staff.

We last conducted a local visit to this service on 21 June 2021. Following our visit we made seven recommendations, this included engaging with and recording contact with relatives and carers, ensuring that an audit of all DNACPR forms are undertaken and that all staff members are aware of the DNACPR status of every patient on the ward. Ensuring that all psychotropic medication is appropriately authorised on T2 or T3 forms with an audit process established; there is a record of who has responsibility for the patients' finances and that all welfare or financial proxy details are clearly recorded; managers promote advance statements and these discussions are clearly documented in the patients' files; managers ensure that the ward environment is welcoming, fit for purpose and refurbished to look less like two distinct wards and lastly that single room accommodation is in place to ensure privacy and maximum benefit to patients.

Who we met with

We met with and reviewed the care and treatment of five patients. As this was an unannounced visit to the service we were unable to meet with any relatives or carers. We spoke with the operational manager, consultant psychiatrist for the ward, the senior charge nurse (SCN), staff nurses, and healthcare assistants throughout the day. Following the visit we spoke with advocacy regarding their input to the ward.

Commission visitors

Justin McNicholl, social work officer

Lesley Paterson, senior manager (practitioners) east team

What people told us and what we found

Care, treatment, support and participation

Our visit was, on this occasion unannounced so patients, relatives, and staff had no prior warning or notification of our arrival. On the day of the visit we were unable to gain access to the ward by using the doorbell to alert staff. As a result we were given access to the ward by a patient, as the clinical team were busy with other duties. After some time we were able to locate a member of nursing staff who alerted the charge nurse to our arrival.

One of the recommendations from our last visit was the limited evidence of family involvement either in discussions regarding the patient's care and treatment or general contact with carers. During this visit it was positive to note increased evidence that engagement with the nearest relative or carers was being recorded by the clinical team in a meaningful way.

During our last visit we found some patients on Arran Ward had DNACPR (do not attempt cardiopulmonary resuscitation) orders in place. The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give cardiopulmonary resuscitation (CPR). Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking necessary steps to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. We found once again that not all staff on duty were completely aware of which patients were subject to the DNACPR policy and the location of these documents.

It is fundamental that all relevant healthcare staff involved in the patients' care are aware that a decision not to give CPR has been made and documented on a DNACPR form. This not only ensures that CPR treatment in not erroneously withheld, but also that inappropriate, contraindicated and/or unwanted attempts at CPR which are of no benefit and may cause significant distress to patients and families is not attempted.

Overall, there was positive feedback from the patients we met regarding their care which was similar to our last visit. Patients seemed comfortable in the company of staff and happy to approach them. We saw staff being proactive and engaging with patients and all the interactions we observed were warm, friendly and respectful. Patients spoke favourably about their care on the ward and nursing staff were knowledgeable about their patients. The nursing care plans of the patients we reviewed were person-centred and recovery focussed. We noted a minority of care plans did not include a signature from the patients or an acknowledgment of their inability or refusal to sign. This is a matter that the ward management agreed to review and we look forward to seeing progress on this when we next visit. The risk assessments we read were detailed, regularly reviewed, and we saw individual risk management plans included in the patients' records.

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/node/1203

We saw clear evidence of regular MDT input with two MDT meetings taking place per week. It was positive to note the improvement of recording in relation to which key members of the team attended each meeting listed within the notes. We were advised that all patients and their families have open invites to the MDT meetings which ensure their views are included in the decision making process.

We heard from patients and staff that advocacy input to the ward is easily accessible, responsive and the patients find it helpful. Following the visit we spoke with advocacy who reported positive engagement from staff and patients with their input being supplied appropriately at relevant stages of the patient journey.

Recommendation 1:

Managers should ensure that all DNACPR decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

Activity and occupation

Every patient we spoke with was aware of the wide range of activities taking place in the ward including cooking groups, breakfast groups, art and crafts groups, quizzes, dominoes, bingo, walking groups, gardening, relaxation, music, internet and film sessions. It was positive to note that since the easing of Covid-19 restrictions that patients who can leave the ward have increased outings and activities. The files we reviewed contained comprehensive occupational therapist (OT) functional assessments, reviews, a structured activity planner and a weekly activity programme.

In discussion with patients, the response to the range and level of activities was mixed. Some stated that they felt the balance was right and that they enjoyed participating, while others commented that they were bored. Whilst recognising the individualised comments and length of stay for some patients, we fed this back to the SCN.

Use of mental health and incapacity legislation

On the day of our visit, 16 of the 20 patients in Arran Ward are detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Part 16 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. Unfortunately despite a recommendation made on our last visit, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were not all in place where required, and some which were did not correspond to the medication being prescribed, meaning there were instances where psychotropic medication was being given without the legal authority to do so.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. It would seem from speaking with staff and patients on Arran Ward and reviewing the clinical notes that advanced statements continue not to be promoted despite our previous recommendation. On speaking with ward staff they remain unclear on which patients have them and which do not and have identified a lack of knowledge on their use.

The Mental Welfare Commission has produced advanced statement guidance which can be found at: https://www.mwcscot.org.uk/node/241

Recommendation 2:

Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on both a T2 or T3 form, where required, and a system of regular auditing compliance with this should be put in place.

Recommendation 3:

Managers should ensure that staff have good awareness in relation to advance statements, which should be promoted with patients in the ward and these discussions be clearly documented in the patient's clinic notes and care plan.

The physical environment

The physical environment of the ward was noted to have improved since our last visit. In particular there were new paintings located on the walls of the corridors as well as new art work on display in the courtyard area. It was positive to note that aspects of the recommendation from our previous visit had been acted upon. These actions have improved the stark clinical appearance of the ward. We note there continues to be work planned to improve the courtyard and garden with new raised beds due to be purchased. This will hopefully improve the overgrown and untidy areas.

One of the ongoing challenges facing the ward is that the signage, at the main entrance to the hospital and at the ward itself continues to display 'Arran and Bute'. This was pointed out to the operational manager during our visit who agreed that this matter needs to be addressed to ensure there is a clear distinction between the previous ward set up and the newly established single ward.

We noted that since our last visit there continues to be no change in patients sharing dormitories. Many inpatient areas across NHS Greater Glasgow and Clyde have been refurbished to provide patients with individual rooms and we continue to strongly encourage managers to consider the same for Arran Ward to ensure privacy and to protect the dignity of the patient. This is especially significant given the fact that many of this particular group of patients in the recovery part of the ward can be in hospital for fairly lengthy periods of time.

Recommendation 4:

Managers should consider ward refurbishment to provide single room accommodation to ensure privacy and maximum benefit to patients.

Summary of recommendations

1. Managers should ensure that all DNACPR decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

2. Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on both a T2 or T3 form, where required, and a system of regular auditing compliance with this should be put in place.

3. Managers should ensure that staff have good awareness in relation to advance statements which should be promoted with patients in the ward and these discussions be clearly documented in the patient's clinic notes and care plan.

4. Managers should consider ward refurbishment to provide single room accommodation to ensure privacy and maximum benefit to patients.

Good practice

We were pleased to see that the clinical team have proactively engaged with Adult Support and Protection procedures led by the local Health and Social Care Partnership. The recording of these meetings was fully evidenced in patient files and formed part of their care planning, risk assessment and management.

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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