Mental Welfare Commission for Scotland

Report on announced visit to: East Ayrshire Community Hospital, Marchburn Ward, Ayr Road, Cumnock KA18 1EF

Date of visit: 8 May 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.

Marchburn ward is a twelve-bedded unit, providing care and treatment for older adults with complex care needs. On the day of our visit there were eleven patients on the ward.

We last visited the service on 18 November 2018, and made recommendations regarding care planning, the environment and communication with proxy decision makers.

Who we met with

We met with and reviewed the care and treatment of six patients, and we met with one relative and spoke by telephone to two other relatives.

We spoke with clinical service manager, senior charge nurse (SCN), and other nursing staff who were on duty on the day of the visit.

Commission visitors

Mary Leroy, nursing officer
Yvonne Bennett, social work officer

What people told us and what we found?

Care, treatment, support and participation

We were not able to have detailed conversations with all the patients in the ward, because of the progression of their illness. However, we were able to meet and introduce ourselves to a number of patients on the ward and they appeared settled and relaxed in the environment.

On the day of the visit we saw positive interactions between staff and patients. When patients were showing signs of stress or distressed behaviours, the staff responded promptly to the patient's needs. On speaking with the staff during the day we were aware they had a strong commitment to meeting the patient's needs; there was a caring approach and enthusiasm by the staff team in the ward.

We spoke with three relatives who were very positive about their contact with the medical and nursing team. They commented on how they appreciated regular updates from the consultant psychiatrist and felt included in their relatives' care and treatment. Two of the carers did comment on the "use of bank staff due to staff shortages" and the implication this could have on the consistency of care. The relatives also spoke about the interactions with the nursing team as being supportive, especially during times when visiting was restricted. For one relative, they raised a specific concern with us. We discussed this with the SCN, who advised us that they planned to meet with the relative to resolve the issue.

Care planning

We wanted to follow up on our previous recommendation regarding care planning. All the care plans we reviewed were person-centred and provided an accurate reflection of the care delivered. There were detailed care plans for physical and mental health needs, care plans for the management of stress and distress that incorporated information on triggers and management strategies. We did note that the care plan reviews were inconsistent, with a lack of detail in some cases. Many of the reviews appeared to be a copy of the care plan; the reviewing of a care plan should detail progress and changes in the care provided.

Chronological notes were detailed and it was clear that the staff team knew their patients, and their families very well, and they were providing person-centred care.

There were detailed risk assessments that contained an informed life history. The risk management plans that were in place for each patient were regularly reviewed throughout the patient's journey.

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

Recommendation 1:
Managers should carry out an audit to ensure that care plan reviews are consistent, and that there is clarity around content, actions and patient progress.

Multidisciplinary team meeting/ input

The documentation of the multidisciplinary meeting (MDT) meeting was detailed and provided a good record. The MDT meetings are held on a weekly basis.

The clinical team input into the unit is primarily from medical and nursing staff. Other allied health professional input could be accessed via referral.

On review of patient care and treatment there was little evidence of input from the wider multidisciplinary team. Given the complex needs of the patient group and the unit being a specialist unit for patients with dementia, there is the need for access and involvement of the wider multidisciplinary team to support nursing and medical staff in the delivery of complex care.

The SCN and team made us aware that there had previously been input from a trainee psychologist who attended the ward on a regular, but sessional basis. We were told that the trainee had since now moved on, and to date this role has not been replaced; given the complex needs of this patient group, this input would be beneficial to the service.

Recommendation 2:
Managers should review staffing arrangements to ensure that patients have access to the full range of professionals required to meet their needs.

Use of mental health and incapacity legislation

On the day of our visit there were no patients subject to the Mental Health (Care and Treatment) (Scotland) Act 2003.

Where individuals had a granted a Power of Attorney (POA) or guardianship order under the Adults with Incapacity (Scotland) Act, 2000 (AWIA) a copy of the powers should be held in the patients care file, and on Care Partner, the electronic file which contained an alert/flagging section for all legal documentation. There was evidence that the proxy decision maker was being consulted with, however we could not find copies of the powers in many of the files we reviewed.

Section 47 of AWIA authorises medical treatment for people who are unable to give consent. Under section 47 authorisation, a doctor, (or another health care professional who has undertaken specific training) examines the person and issues a certificate of incapacity. We could not find the section 47 certificates in some of the files we reviewed. The staff informed us of the completion of a s47, and the associated treatment plan for administration of Covid-19 vaccinations; these copies were on files. We were told that the patient also had another s47 certificate which detailed other treatments. For some patients those certificates were not available for review.

Recommendation 3:
Managers should undertake an audit to ensure that where there is a proxy decision maker, and a copy of the powers granted are on file.

Recommendation 4:
Managers should ensure that s47 treatment plans are completed, available and correctly filed in accordance with the AWI Code of Practice (third edition).

Rights and restrictions

Marchburn is a locked ward and has a "locked door policy", which is proportionate with the level of risk being managed in this type of care setting.

The ward continues to work with a booking system for visits, in line with the Covid-19 restrictions that were in place at the time of our visit. There were plans to review this in line with Scottish Government guidance. Whilst restrictions were in place, staff have proactively contacted relatives and facilitated virtual visits and when possible, garden visits for relatives. The ward had 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

In common with other services we have visited recently, the surge in clinical demand has resulted in a reduction by the service to offer an optimum level of meaningful activity in a busy ward.

Nursing staff have provided activities on an ad-hoc basis. Due to the nature of the patient's needs, most activities are on a one-to-one basis and included hand massage, reminiscence, going for a walk in the garden or simply having a chat.

We saw staff engaging in activities during our visit. We also were advised that due to the pandemic there had been an absence of links with community activities, and that this has had a significant impact on patient care.

We noted from our previous visit that there had been a fuller schedule of activities provided by both nursing staff and community activity providers. We discussed with staff on the day about the benefits and improvement in clinical outcomes for patients when there is increased staff and patient interaction and increased patient activity that is both therapeutic and recreational.

Recommendation 5:
Managers should review ward activities to ensure they best meet the patient's needs in a specialist complex dementia care unit.

The physical environment

The colour scheme is bright, cheerful and dementia friendly, using colour to highlight doorways and, handrails etc. The bedrooms are all en-suite.

There are two large and expansive communal sitting areas, and although there is little natural light, the staff have ensured that there are seats positioned under any natural light in the area. They have also identified and positioned further seating in other quiet areas in the ward.

Both small dining rooms have access to views of the garden and natural light. There is also a family room situated in the ward.

There are two enclosed garden spaces that are dementia friendly. We were told of the plans for painting the woodwork and creating a raised bed, along with the need for some general garden maintenance. The area is well planted and provides a calm, outdoor space for patients.

Admission to hospital can be distressing for people with a diagnosis of dementia and we know that appropriately designed surroundings can reduce this. As noted above, the clinical team have made some simple adaptations that improves the quality of care setting.

We were told by senior management of future plans regarding the need for a full redesign of the ward, to ensure that it is dementia friendly, giving consideration to a number of environmental factors, such as appropriate flooring, ceiling and sound absorption, signage and lighting, respective rooms for physiotherapy and occupational therapy, and good access of views to the garden.

Any other comments

We were told that the ward currently has five registered nurse staff vacancies. The team also discussed the challenges recruiting staff to those vacancies. As a result there are difficulties providing adequate staffing cover, and the ward has been using bank staff. We were informed the service is in the process of re-advertising the vacancies.

Summary of recommendations

1. Managers should carry out an audit to ensure that care plan reviews are consistent, and that there is clarity around content, actions and patient progress.

2. Managers should review staffing arrangements to ensure that patients have access to the full range of professionals required to meet their needs.

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.

4. Managers should ensure that section 47 treatment plans are completed, accessible and correctly filed in accordance with the AWI Code of Practice (third edition).

5. Managers should review ward activities to ensure they best meet the patient's needs, within a specialist complex dementia care unit.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk