Mental Welfare Commission for Scotland

Report on announced visit to: Seafield Hospital, Muirton Ward, Buckie, AB56 1EJ

Date of visit: 10 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 able to be carried out face-to-face.

Muirton Ward is an older adult assessment unit for people with dementia. The ward has eight beds and on the day of our visit there were eight patients on the ward. We last visited this service on 30 January 2020 and made recommendations about care plans, do not attempt cardio pulmonary resuscitation (DNACPR) forms and section 47 treatment plans.

On the day of this visit we wanted to follow up on the previous recommendations and speak with patients, relatives and staff.

Who we met with

Prior to the visit we met with the senior charge nurse (SCN) and clinical nurse manager via video call. On the day of the visit we spoke with a range of nursing and ward staff, including the junior doctor. We were made aware that the SCN has since left the post and a replacement SCN has been recruited. Links with the local advocacy service were also made prior to the visit.

We spoke with and reviewed the care and treatment of four patients and spoke with two relatives.

Commission visitors

Tracey Ferguson, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

During our visit, we introduced ourselves and chatted with patients on the ward. We were not able to have detailed conversations with all patients, because of the progression of their illness, however most patients appeared relaxed and content in the ward environment.

We observed supportive interactions between ward staff and patients during our visit and from speaking to the staff team, we got the sense that they knew the patients well. We were concerned about a patient where we saw little interaction between staff and the patient. We followed this up with the SCN, as we wanted to know how staff were managing this patient's stressed/distressed behaviour.

Feedback from relatives about the ward staff was positive. They told us that the staff were very caring and kind. The ward had recently been closed due to an outbreak of Covid-19, however relatives told us that staff kept in regular touch and they were pleased when the ward opened again for visiting.

Managers told us about the ongoing staffing challenges in trying to fill staff vacancies and recognised recruitment of nurses is a national issue; it can be more difficult to recruit in rural areas. We were told about the continued proactive efforts to recruit staff and how the ward currently uses regular agency nurses, to ensure continuity and safe delivery of patient care.

Nursing care plans

In patient files we saw a detailed nursing assessment that was completed on admission, along with a robust risk assessment and management plan. This assessment provided a detailed background history along with the purpose for admission. The ward uses a named nurse system and this was documented in the notes. Some files had completed 'Getting to know me' booklets, that were completed with help from relatives and provided a good life story of the patient's background.

We saw evidence of robust physical health care monitoring on admission and throughout the patient's journey. Where covert medication pathways were in place, we saw appropriate documentation, including a detailed reason for the need to use this along, with appropriate review. There was evidence of one-to-one sessions with nursing staff in the notes, however we found some entries where the use of language was not patient centred, nor was it written in a positive manner. We brought this to manager's attention.

We wanted to follow up on our last recommendation regarding care plans. We saw some evidence of detailed care plans, with regular reviews taking place and some level of evaluation. It was positive to see some daily nursing note entries linked to care plans, however we found that many of the care plans were assessment-based and had not been updated since the patient's admission. Following the assessment period, we would expect to see a detailed individualised care plan that records detailed interventions to support the patient to meet their goals.

We wanted to find out how staff were supporting patients with stressed/distressed behaviours. We were told that most staff have undergone stress/distress training and two staff members have undergone further training to be appointed ambassadors in the service.

We therefore expected the care plans to be very person-centred, with detailed interventions in ways to support the patient with their stress. However, we found a lack of detail in the stress/distress care plans, and a lack of supporting documentation. Many care records indicated the use of non-medical strategies to support patients, however these were not specifically identified in the care plan, nor were the triggers that were noted to cause the patient's distress. We therefore found that some patients were given as required medication to reduce symptoms of stressed and distressed behaviours, rather than first utilising non-medical interventions.

Given that care planning was a recommendation on our last visit, there appeared to be little improvement, so we wanted to find out what action has been taken by managers. We are aware that in the service as a whole, care plans and reviews were being worked on, however managers told us that due to the pandemic, audits of patient notes has not been carried out.

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

All patients on the ward had recorded in their care plans that they were unable to sign the care plan due to lack of capacity. We were told that discussion is held with relatives and proxies about the care plans and we saw this recorded in some, but not all patient files. We brought this to the manager's attention.

We wanted to follow up on our last recommendation regarding DNACPR. Where DNACPR forms were in place, we were pleased to see that consultation with the proxy/relative was recorded.

Recommendation 1:
Managers should re-introduce regular auditing of the patient's notes, including the care plans to ensure that they reflect and detail interventions which support patients towards their care goals, along with regular reviews and summative evaluations.

Multidisciplinary team (MDT)

There are two consultant psychiatrists that cover the ward and we were told that multi-disciplinary meetings (MDT) continue to take place weekly and the ward continues to have access to allied health professionals (AHP's) and psychological services via a referral system.

The MDT minutes were variable in the level of detail recorded, along with actions and outcomes. In the MDT minute it was clear to see who attended the meeting, along with who was responsible to feedback to the relative, which was positive. There were separate recordings of the MDT minute in the medical notes and nursing notes and we emphasised to the service that both records should replicate the same information and perhaps a way forward would be to have one record of the meeting.

In relation to discharge planning it was good to hear from the service that there continues to be proactive work around discharge planning, thus preventing patients from being in hospital longer than necessary.

Care records

Patient files are paper based and there is a separate file for nursing and medical staff. The files have separate sections for information and they appeared organised and easy to navigate around.

Use of mental health and incapacity legislation

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) we found that the MHA paperwork was in order, along with the authorising treatment forms (T3) completed by the responsible medical officer to record non-consent.

Administration of "as required" intra muscular (IM) psychotropic medication almost always requires the legislative authority of the MHA. The Commission is concerned when IM 'as required' medication is being prescribed for informal patients. This is because it is unlikely that there would be consent to receive this treatment if it had to be administered in circumstances where restraint may be required. We consider it best practice for a medical review to be arranged if there are exceptional circumstances where IM medication may be required. We found that two patients had been prescribed IM medication, but had not required this to be administered. The Commission is continuing to follow up this matter with another service in NHS Grampian and has agreed that the managers of Muirton Ward will be included as part of any follow up discussion/advice.

Recommendation 2:
Managers should ensure intramuscular "as required" psychotropic medication is not prescribed for informal patients other than in exceptional individual circumstances.

For patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 (AWIA) we saw a copy of the legal order in the file. There were some entries that recorded the patient was subject to AWIA, rather than the specific legal order. We brought this to the manager's attention, as this lack of clarity regarding the measures authorised under AWIA legislation could lead to confusion.

We wanted to follow up on our previous recommendation regarding section 47 treatment plans. Where individuals are assessed as lacking capacity to consent to treatment and they are being provided with treatment under part 5 of the AWI Act, section 47 certificates authorising treatment should be completed. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We viewed one patient's s47 treatment plan, where it had been recorded that the patient lacked capacity to make decisions regarding placement of care. We discussed this further with the clinical team on the day. A s47 certificate provides authority only for medical treatment under part 5 of the AWIA and does not provide legal authority regarding welfare matters.

We saw that all patients had a s47 completed, however the completed treatment plans were variable and not all completed in accordance with the AWIA code of practice for medical practitioners. We were disappointed to see that no improvement had been made since our last visit. This matter will be escalated to senior managers in NHS Grampian and Moray HSCP.

Rights and restrictions

The ward has a locked door policy in place and we saw individual risk assessments that identified patients who would be at risk if the door were opened, due to their vulnerability and progression of their illness. There was a locked door policy displayed on the front door.

The ward continues to have good links with Circles Network advocacy service, who visit patients on the ward and support patient's awareness and understanding of their rights.

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

On the day of the visit we wanted to find out more about ward based activities. On our previous visit the ward recorded patient activities in a separate folder and had a dedicated activity room. However we were told that this room had to be used for other functions during the Covid-19 pandemic and activities are no longer recorded separately in the folder. The ward does not have a dedicated activity coordinator/therapist to plan and coordinate group or one-to-one activities. We heard that nursing staff deliver all activities, however this can be inconsistent due to staffing pressures. This was evident on the day of our visit, as no activities were planned or took place due to other nursing tasks taking priority.
We found little evidence in patient notes of activities, which was disappointing, particularly as activities can support patients in managing stress/distress behaviours, often resulting in the decrease in medication administered to manage such behaviours.

We did hear that recently the area OT has been linking in with one of the ward nurses, who has an interest in activities. They are looking at ways that activities can be delivered on the ward, however this is in very early stages. Given that day-to-day nursing tasks must take priority, it is of concern that there is no dedicated patient activity staff to support the patient group and offer activity based therapeutic interventions.

Recommendation 3:
Managers should ensure that activities are being delivered as part of individual care plans and recorded in patient files.

The physical environment

The ward was bright and spacious with a corridor that led to single rooms and shared dormitories. Dementia friendly signage was on display throughout the ward, which helped patients to find their way around the ward. Throughout the day we observed patients walking up the spacious corridor or sitting in the main dining/lounge area. The ward has a quieter

lounge and a large enclosed observatory with access to an enclosed garden. We were told that the garden area cannot be used at present due to a broken window on the shed that occurred from a previous storm. Managers told us that this has been raised with estates however were unsure when this will be repaired. We were disappointed to hear that this has not been fixed, meaning that patients/visitors cannot access the outdoor space, especially in the current warmer weather. Outdoor space can be beneficial in improving patient wellbeing, but also managing patients stress/distress. We consider that it is important for patients to have access to outdoor safe space.

Recommendation 4:
Managers should ensure that the garden area is safe for patients to access and any repairs outstanding should be attended to as a matter of priority.

Any other comments

While we were aware of the challenges faced by patients in relation to the Covid-19 pandemic, we were equally aware of the impact the Covid-19 pandemic has had on staff. We were impressed to see and hear that the staff have continued to provide a quality service despite the numerous challenges presented to them, including staff shortages. The ward had a recent Covid-19 outbreak, however we heard how the staff worked hard, supported by infection control guidance to contain the outbreak successfully. Given that the ward has had changes in the leadership team, we were pleased to hear that a new SCN has been appointed.

Summary of recommendations

1. Managers should re-introduce regular auditing of the patient's notes, including the care plans to ensure that they reflect and detail interventions which support patients towards their care goals, along with regular reviews and summative evaluations.

2. Managers should ensure intramuscular "as required" psychotropic medication is not prescribed for informal patients other than in exceptional individual circumstances.

3. Managers should ensure that activities are being delivered as part of individual care plans and recorded within patient files.

4. Managers should ensure that the garden area is safe for patients to access and any repairs outstanding should be attended to as a matter of priority.

Service response to recommendations

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

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