Mental Welfare Commission for Scotland

Report on announced visit to: New Craigs Hospital, Ruthven Ward, 6-16 Leachkin Road, Inverness IV3 8NP

Date of visit: 13 July 2022

Where we visited

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. From August 2020, the Commission is undertaking a phased return to our visit programme following recommendations in the Scottish Government's roadmap to recovery. This local visit was undertaken using in person interviews on site at New Craigs Hospital.

We were keen to visit Ruthven Ward as the last Commission visit was in 2020 and we wanted to see find out how the new environment has impacted on patient care following the merging of Clava and Torvean wards.

Ruthven is a 24 bedded mixed-sex dementia assessment and complex care ward, restricted to occupancy level of 22 patients, which was the occupancy at the time of the visit. The ward is split in two with 11 patients in each side and this seems a more manageable group to nurse. The gender mix can be problematic but the nurse-patient ratio allows for better observation of patient interactions. The ward is served by five consultants, each covering a geographical area.

Patients who are admitted to Ruthven 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 Ruthven 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 has raised levels of risk as a result of their presentation.

On our last visit we made the following recommendations; care plans should be more person centred; care records should be completed consistently; the range of therapeutic and recreational activity provision should be increased; dementia environment assessment should be undertaken; and copies of consent to treatment certificates should be located beside the drug prescription sheets.

The response we received from the service provided an action plan to address the issues identified in the report.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the new environment and its impact on patient care. This is because the previous environment was not appropriate for this patient group due to shared dormitories, difficult access to the ward, unsuitable garden space and poor bathing facilities.

Who we met with

We met with and reviewed the care and treatment of eight patients.

We spoke with the service manager, the charge nurse and other clinical staff.

Commission visitors

Margo Fyfe, senior manager (practitioners)

Douglas Seath, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met during the visit had difficulty in offering verbal feedback as to 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.

We saw some evidence of a more person-centred and strengths-based approach in care planning. In the care plans we reviewed, we noted that risk assessments were documented but some had not been reviewed on a regular basis. A number of plans which we looked at lacked detail. In two of the files we reviewed, we found that the care plan had not been updated to reflect changing needs. We found that the quality of care plans varied with some including a clear overview of the patient's situation and needs, followed by detailed interventions for each identified need. However, there were a number of care plans which attempted to cover too broad a range of needs and issues in one plan. As a result, those care plans lacked focus and did not fully reflect the high quality care which was being provided. We also looked at reviews of care plans and it was our view that these could be more comprehensive and take account of changes in the patients' presentation and the impact of the nursing interventions. The need for improvement has already been recognised in 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 that 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 in this setting – a large number of patients from Ruthven 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 in the new placement.

Patient involvement in care plans was difficult due to the severity of cognitive impairment, and we hoped this might be offset by greater involvement of family/carer involvement, with care plans signed off by relatives, where appropriate. However, we did not find 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. Although there was evidence of contact with families by the named nurse, there did not appear to be regular attendance of relatives at review meetings.

There was evidence of regular multidisciplinary meetings (MDTs) with attendance from the multi-disciplinary team, depending on the needs of the individual patient. MDT notes provided a summary of recent presentation and care needs, however these were brief, and lacking in detail on decisions taken and follow up action required.

There are no dedicated occupational therapy or physiotherapy sessions allocated to the ward, however these services along with dietetics and speech and language therapy are available on a referral basis. The physiotherapist input was very detailed with extensive records in the care file. We discussed and noted involvement of psychology in supporting the care and treatment of patients with complex needs. The psychologist leads on the development of formulations to support the complex care needs for some patients. Plans which detailed how staff would support a patient who became stressed or distressed were particularly clear and comprehensive.

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 ensure MDT notes contain information on decisions taken and actions required.

Recommendation 2:

Managers should audit care plans to ensure all individual plans reflect current needs and ensure that reviews are timely and meaningful.

Use of mental health and incapacity legislation

On the day of our visit, 13 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Mental Health Act paperwork in the records was well maintained and easy to access. 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. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order.

Where patients had been assessed as requiring medication covertly, we saw detailed covert pathways in the files, along with appropriate reviews.

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), we would expect to see copies of the legal order in place but could not locate some on the day. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the four principles of the Act. Section 47 consent to treatment certificates were all in order for each patient, along with accompanying detailed treatment plans.

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 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 what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. In 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- or with nearest relative. We noted that these certificates had, at times, been signed off prior to the patient being admitted to Ruthven 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 found where there was a proxy, this was generally recorded in the care files we reviewed. There was some evidence that they were being consulted, however we could not find copies of the powers in some of the files. We discussed this on the day of our visit and were assured that this will be followed up by the senior charge nurse.

Recommendation 3:
Managers should ensure that copies of proxy powers are located in relevant patient files for all staff to access.

Recommendation 4:
Managers should carry out an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Rights and restrictions

Due to the complex needs of the patients, Ruthven Ward operates a locked door policy and we were satisfied that this restriction was commensurate with the needs of the patients. The ward had until recently been working with a booked visiting system, in line with the Covid-19 restrictions which were in place. The ward has now returned to open visiting in line with current Covid-19 guidance. Whilst restrictions were in place, staff proactively contacted relatives and facilitated virtual visits using a variety of platforms. The ward has 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

We heard from some patients that they did not have access to regular meaningful activity and as a result felt that it was “a long day” on the ward. During our visit we saw a number of staff engaging with patients in a range of activities, or simply spending time chatting with them. We discussed this further with the staff and were advised that there are no ward-based activity coordinators and that this is by default the responsibility of the ward staff. This has been

difficult to prioritise against a backdrop of increased clinical need and staff shortages as a result of Covid-19 absences and vacancies. There is an Occupational Therapist but shared with another ward and mainly involved in assessments towards discharge planning. Some groups have resumed and there are plans to resume more regular activities as services enter the recovery phase. We would urge managers to consider the value of having dedicated activity coordinators in the ward to ensure that meaningful activity can be delivered routinely. We look forward to seeing progress in this area on future visits.

Recommendation 5:
Managers should ensure that there are programmes of activity in place for each individual and review how this can best be delivered.

The physical environment

Ruthven Ward offers a pleasant environment with patients accommodated in single rooms with en-suite facilities and access to communal areas that are well maintained. Patients have access to an enclosed garden area and courtyard which is in the process of being remodelled to offer a more pleasant outside space. The layout is conducive to having the ward managed as two smaller units, as is the current practice.

However, the ward was not originally designed as a dementia assessment facility and so there will be refurbishment plans developed to give a more dementia friendly focus. Funding has been identified to support this and the SCN is involved in the planning and design. We look forward to seeing the result in future visits.

Any other comments

We saw a separate section in patient's files where there were referrals to, and the involvement of other services such as physiotherapy and dietetics. There did appear to be unnecessary bureaucracy involved in formal referral to a service which is regularly visiting and engaged with patients within the ward.

However, the ward manager was enthusiastic about their plans for development of a high quality service for older adults with dementia. They advised us that only staff who are keen to work in this specialty would be employed in the unit and when recruiting unregistered nurses they prefer them to have previous experience in the care sector. All the nursing staff are given training in stressed and distressed behaviour. At present there are only two nursing vacancies on the ward and the aim is to work with a 1:2 nurse patient ratio during the daytime hours. Any bank or agency nurses employed are all familiar with the ward.

Summary of recommendations

1. Managers should ensure MDT notes contain information on decisions taken and actions required.

2. Managers should audit care plans to ensure all individual plans reflect current needs and ensure that reviews are timely and meaningful.

3. Managers should ensure that copies of proxy powers are located in relevant patient files for all staff to access.

4. Managers should carry out an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

5. Managers should ensure that there are programmes of activity in place for each individual and review how this can best be delivered.

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.

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