Mental Welfare Commission for Scotland

Report on announced visit to:

South Ward, Dykebar Hospital, Grahamston Road, Paisley Renfrewshire PA2 7DE

Date of visit: 17 November 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.

South Ward is a 15- bedded single room unit with en-suite facilities. The ward is an acute adult assessment unit with male and female patients covering the Paisley and Renfrewshire area. On the day of our visit there was one vacant bed due to the room having new flooring fitted.

We last visited this service on 14 October 2019 and made recommendations relating to care plans and recording on EMIS. On the day of this visit we wanted to follow up on the previous recommendations and also to hear how patients and staff have managed throughout the pandemic

Who we met with

We met with, and reviewed, the care of seven patients, five of whom we met with in person and two we reviewed the care notes of. We also met with one relative.

We spoke with the lead nurse and the nurse in charge on the day of our visit.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patient group well, and they seemed to enjoy their work as we witnessed warmth, care and understanding between staff and patients.

All of the patients that we spoke to had only praise for the staff team. One patient who had been in the ward for some time described the staff team as "brilliant" but commented there were not enough staff. Another patient commented that they were concerned that at times, staff didn't get their breaks. From the other patients, we heard that staff were "lovely" and kind, the patients felt listened to and involved in their own care decisions, that staff were really good, they were approachable, communicate well and take on board what patients say to them; we also heard that the consultant is very approachable that the patients feel listened to. We did hear from one patient that they felt was communication was poor; the details of this comment were shared with the charge nurse and the lead nurse at the feedback session.

On the day of our visit, initially the ward was calm, however, during the day there were noisy outbursts that gave other patients cause for concern, and several advised us that they felt vulnerable and fearful. We heard that the ward could be "chaotic" but the staff managed it well. When we discussed this with the charge nurse and lead nurse, they were aware of these concerns and working to try to reduce the incidence of outbursts.

There were three patients who were on enhanced observations when we visited. All three patients required one-to-one nursing care and this had an impact on the ability of staff to care for all of the patients in the ward.

Care Plans

When we last visited the service we made recommendations about what we would have expected to see in a patient's care plan. We found that there had been little improvement to care plans and there were no reviews or evaluations on file. When we spoke to the nurse in charge and the lead nurse at the end of our visit, they acknowledged that care plans were not of an acceptable standard.

When we reviewed the care plans we were unable to locate robust reviews which targeted nursing intervention and an individual's progress. We heard that reviews were happening but this was not reflected in the paperwork. We were advised that care plans and reviews are being worked across the service on and suggested using the Commission guidance to help in the process. We recommended that an audit of the care plan reviews was carried out to ensure that they reflected the work being done with individuals towards their care goals, and that the reviews were consistent across all care plans.

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 of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Care records

Information on patient care and treatment was held in two ways; there was a paper file and the electronic record system, EMIS. We found this easy to navigate and noted that the information on EMIS was more detailed and meaningful. However, we were concerned that should the electronic system be unavailable, especially when information was required to be quickly accessible, what was held on the paper file may not provide enough detail. We were assured that discussions were ongoing with the IT department to ensure that in future, most information can be saved to the EMIS system.

We found that the daily notes that were recorded on EMIS were good and gave comprehensive information about the patient and their activity during the day. The notes were person-centred, concise and provided evidence of the care that was delivered. There was also evidence of patients having one-to-one discussions with their named nurse on a regular basis. We saw that physical health care needs were being addressed and appropriately followed up in a timely way.

In the daily care notes, we found robust risk assessments on file, as well as on EMIS, that were detailed and of a high standard.

Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) of nursing staff, psychiatrists, occupational therapy staff, psychologists, and speech and language therapy staff. Referrals can be made to all other services as and when required. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and update on their views. This also includes the patient and their families should they wish to attend.

We heard that meetings had been held online during the restrictions and this had enabled more professionals to attend. MDT meetings have now returned to face-to-face consultations. Family members who wished to attend were able to do so if the patient agreed.

We were unable to find clear discharge planning information in the MDT meeting notes and spoke with staff about ensuring that this was added to all versions of the meeting note.

Use of mental health and incapacity legislation

On the day of our visit, nine of the 14 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act. Two patients who were informal told us they had been given a booklet on their rights as an informal patient and also what it meant to be detained.

All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) 2000 Act (AWI), including certificates around capacity to consent to treatment, were in the paper files and were up-to-date.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed. There was a discrepancy with one T2 which was brought to the attention of the charge nurse and she immediately contacted the responsible medical officer for it to be corrected. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up to date.

Recommendation 2:
Managers should ensure that copies of all treatment forms - T2, T3, section 47 certificates and treatment plans and covert medication pathways - are stored with the drug prescription sheet until the phased transfer of prescription details to HEPMA.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. There were no patients on the ward in this category on the day of our visit.

There were no patients on the ward requiring the use of covert medication. Where there is the Commission has produced good practice guidance on the use of covert medication at:
https://www.mwcscot.org.uk/node/492

Rights and restrictions

South ward continues to operate a locked door policy, commensurate with the level of risk identified in the patient group. The unit door is locked and entry is via a buzzer or keypad. Information on this is provided to families and other visitors and was visible on the day of our visit. South Ward has open visiting and it was felt that this had a positive effect on the patients as family and friends can visit for longer periods during the day.

On the day of our visit there was one patient who was a specified person. Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place, we found reasoned opinions in place,

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We saw no evidence of advance statement recording in the files that we viewed. South ward is an acute admissions ward and it may not be appropriate to discuss advance statements during the early stage of admission but discussion should take place, and a record of this made, at the discharge planning stage.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services and patients to 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

Previously, we had been concerned about patients being on the ward for extended periods of time, and whose discharge from hospital was delayed. We were pleased to hear that there was only one patient whom it was felt was not appropriately placed in the ward; this was acknowledged by the charge nurse and lead nurse who were actively seeking a more appropriate placement for this patient.

Activity and occupation

We are aware that during the pandemic, restrictions that were put in place meant that various activities out with the unit had to be put on hold, and that some of the patient group had struggled with this change to their routine. In South ward, the occupational therapist (OT) was key to supporting patients with activity on the ward. However, we also heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients, particularly at weekends or when the OT is not available. We saw the range of activities on offer and patients were free to participate in any or all of the activities.

The physical environment

The layout of the ward comprised only of single en-suite rooms. There were several quiet/lounge areas and a separate dining area for the patients, all are bright and spacious. The environment was clean and tidy but we felt that although some efforts had been made to soften the public rooms, they were in need of colour and seemed functional and unadorned.

We saw that there was ready access to the garden from the ward which was clearly being used on a regular basis; it was also wheelchair accessible. Whilst some effort had been made to brighten up the garden area, it was in need of some maintenance and some comfortable and inviting furniture. We consider that it is important for patients to have access to welcoming outdoor space.

Staff told us about plans to redecorate and new furniture is on order for both the indoor and outdoor communal spaces.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Managers should ensure that copies of all treatment forms - T2, T3, section 47 certificates and treatment plans and covert medication pathways - are stored with the drug prescription sheet until the phased transfer of prescription details to HEPMA.

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.

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