Mental Welfare Commission for Scotland

Report on announced visit to:

Garry & Tummel Wards, Psychiatry of Old Age, Muirhall Road, Perth PH2 7BH

Date of visit: 30 & 31 January 2023

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.

Garry and Tummel Wards are both 12-bedded wards for the purposes of assessment and treatment for people with dementia. On the day of our visit, neither wards had vacant beds.

We last visited this service on 23 July 2019 and made recommendations regarding the auditing of care plans, authority to treat certificates, discharge planning arrangements and improving the décor in Garry Ward.

During our visit we wanted to follow up on the previous recommendation and hear how patients, staff and relatives have managed throughout the Covid-19 pandemic.

Who we met with

During our visit we reviewed the care and treatment of 11 patients and we also met five relatives.

We spoke with the senior charge nurses (SCN's) on both wards, the consultant psychiatrist for Tummel Ward, and, at the end of the day, we met with the team manager and general manager.

Commission visitors

Alyson Paterson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met during our visit were not able to engage in a discussion about their care and treatment due to the extent of their cognitive impairment. However, we did spend time on both wards, speaking to patients, where appropriate, and observing them. There was a calm atmosphere in Garry Ward; less so in Tummel Ward which was due to the level of acuity of patient presentations. On both wards, we observed nursing staff interacting in a kind and supportive way. We observed a distressed patient being moved in a wheelchair and being sung to by a member of staff. This clearly had a calming effect and demonstrated the benefits of individualised and person-centred interaction, but noted that this beneficial intervention was not detailed in the patient's care plan.

The relatives we spoke to during our visit were overwhelmingly positive about the care, treatment and support on the wards. Staff were described as outstanding, exceptionally kind and that the care and attitude of staff was above and beyond. Relatives told us that staff kept in contact with them and they felt listened to. Some of the relatives we spoke to told us that they had been invited to meetings, others had not. All the relatives we spoke to had been given copies of care plans. The relatives described the ward environment, including the bedrooms as adequate. Comments about food provided in the units were positive, with a range of choices. The laundry service was an issue for one relative who said that clothes were regularly ruined and/or lost.

From staff that we spoke with, we heard how challenging the last two years had been since the start of the Covid-19 pandemic, although we were pleased to hear that there has been a focus on staff wellbeing throughout the pandemic and this has continued.

We heard that the activity support worker had recently trained in 'playlist for life', an evidence-based initiative to support people living with dementia to create a playlist of personally meaningful music, with the aim to reduce stress and distress. We look forward to hearing more about this on our next visit.

We were also pleased to hear about the development of a transitional care (TC) nurse who supports discharge planning. Patients were supported when they had moved from hospital to long-term care for a transitional period, thereby bridging the gap between hospital and community mental health teams. The TC nurse had developed therapeutic care plans to support patients, and these accompany them to their long-term care placement. The TC nurse worked with all care homes across the Perth & Kinross area. As part of the TC role, the service had developed the 'This is ME' poster, which also accompanied the patient to their long-term care placement. The TC role was initially only funded for six months in December 2021, to support transition from hospital to care home. However it was acknowledged that this was a fundamental role in the service to support proactive and robust discharge planning. Funding has since been secured to March 2023, with a view to making this role permanent for the Perth & Kinross older people's in-patient service. The benefits of the TC role had been demonstrated, as out of 100 complex discharges, only one patient has had to return to hospital.

Care records

Information on patients' care and treatment was held mainly on the electronic patient record system, EMIS, along with a paper file. Although the system was relatively easy to navigate, some information was difficult to locate, for example the name of the patient's doctor or social work mental health officer (MHO). The daily progress notes regarding patient care and treatment lacked detail, with inconsistent evidence of specific interventions, such as, the provision of one-to-one support. We read some case records that used negative language, describing the individual as hostile or interfering. We found this language to be unhelpful as it did not provide a clear explanation of the patient's behaviour or suggest supportive interventions. We were pleased when we did read about interventions e.g. offering reassurance, reading a book or holding the hand of a patient. Progress notes showed input from other disciplines, such as occupational therapy (OT), pharmacy, psychology and the activities support worker.

In both wards we were able to locate copies of paperwork such as power of attorney (PoA), guardianship certificates and do not attempt cardiopulmonary resuscitation (DNACPR) paperwork. DNACPR certificates evidenced family, PoA or guardian involvement, where appropriate.

Care planning

Nursing care plans are a tool that identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. NHS Tayside have produced a set of standards, Mental Health Nursing: Standards for Person Centred Planning.

We were pleased to hear that to support the ongoing quality of care plans and documentation, monthly audits were undertaken by the charge nurses in both wards. Action plans were subsequently developed and fed back to nursing staff. We were told that patients and relatives were encouraged to participate in care planning.

During our visit, we reviewed care plans that were held on EMIS. We found them to be person-centred and it was clear that staff knew patients on the ward very well. We saw thorough background personal information in care plans. The care plans we saw addressed a range of needs including mental and physical health needs and outlined goals and interventions required to meet needs. However, some of the care plans we saw lacked detail in terms of what specific interventions were required to meet the desired outcome. In some, what was described as a need was just a statement of fact e.g. the patient is detained.

We saw goals that were generic, for example "to receive appropriate care and treatment". Although there was evidence of review, we would have expected to find detailed summative reviews that targeted nursing intervention and individual's progress to meet specific, patient centred goals.

In the care plans that we reviewed, we found inconsistent evidence of patient and relative involvement. Where patients were unable to fully participate in care planning due to the progression of their illness, we would have expected this to be discussed, agreed and recorded with relatives and carers.

We were however pleased to see detailed and person-centred activity care plans that were updated daily. We would have liked to have seen information from the patient's activity care plan amalgamated into their nursing care plan.

The risk assessments we saw were of a good standard and were detailed, showing appropriate interventions to manage risk.

Recommendation 1:
Managers should ensure that staff completing care plans undertake care plan training and refer to NHS Tayside's person-centred care planning standards.

Recommendation 2:
Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 3:
Managers should ensure that patient/relative involvement in care planning is encouraged and recorded.

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

Multidisciplinary team (MDT)

A range of professionals were involved in the provision of care and treatment in the wards or accessible to them. This included nursing staff, health care support workers, a consultant psychiatrist for each ward, a speciality/junior doctor and a ward clerk for each ward. OT, pharmacy, physiotherapy, psychology and speech and language worked across the service and their involvement was dependent on individual patient care needs. Additionally there was an allocated social worker per ward area and a transitional care nurse who worked across the wards, supporting discharge planning and transitional care.

We were told that there were a number of vacant posts across the two wards. This included nursing staff, an activity support worker and a ward clerk. We heard that the service regularly used bank and agency staff and that there were retired nurses who provided cover which ensured continuity for patients.

We heard that MDT meetings were held every week along with daily huddles, which were brief and focused meetings. Although there was a template on EMIS to record MDT meetings, we found that this was inconsistently completed. We would have liked to have seen information such as the date of the meeting, names of those attending the meeting, the patient's legal status and family involvement to be fully completed for every meeting held. We would also have expected to see more detailed actions recorded for those whose discharge from hospital had been delayed. We fed this back to managers at our end of day meeting and were advised that this would be taken forward. It was not clear if patients and/or their family were invited to clinical team meetings as this was not recorded.

Recommendation 4:
Managers should ensure that MDT meetings are fully recorded including patient/relative involvement.

On the day of our visit, we were concerned to hear that 83% of patients in Garry Ward and 25% in Tummel Ward had discharges that were delayed. This means that these patients have remained in hospital despite being clinically fit for discharge. We heard this that this was mainly to do with the lack of appropriate care home placements in the Perth and Kinross area, along with patients requiring a guardianship order to authorise their discharge. The Commission is of the view that discharge planning should begin as early as possible, preferably on admission, to prevent patients having to remain unnecessarily in hospital. One patient had been delayed for over 16 months. We would like to see managers working closely with their colleagues in social work to ensure a solution to this issue can be found.

Use of mental health and incapacity legislation

On the day of our visit, one patient was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) on Tummel Ward and four in Garry Ward. When a patient is subject to compulsory measures under the Mental Health Act, we would expect to see copies of all legal paperwork in the patient's files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. Treatment must be authorised by an appropriate T2, T3 or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we found no issues regarding the legal paperwork required to detain patients. We identified one issue on a certificate authorising treatment under the Mental Health Act (T3) which we raised with the consultant psychiatrist during our visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (AWIA) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of Act. On reviewing patients' files, we found that prescribed treatment was not fully described in the section 47 certificates. We also found certificates in Tummel Ward that contained abbreviations that were not widely understood by the clinical team.

Recommendation 5:
Managers should ensure that where a patient lacks capacity in relation to decisions about medical treatment, s47 certificates and treatment plans must cover all relevant medical treatment the individual is receiving. Treatment should be described in full and abbreviations should not be used.

Where patients are subject to power of attorney (PoA) or guardianship under AWIA, we would expect to see a copy of the certificate in the patient's file. We were able to easily locate copies of PoA and guardianship certificates, with associated powers, in the patients' paper files.

Rights and restrictions

Due to the complex needs of the patient group in Garry and Tummel Wards, a locked door policy is in place. We were satisfied that this was proportionate in relation to the needs of the patient group.

When we review patients' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and they are written when a person has capacity to make decisions on the treatments they want or do not want in the future. Health boards have a responsibility to promote advance statements. We were advised that no patients on Garry or Tummel Ward have advance statements. However, the service have advised us that this an area for improvement and as such, an audit will take place with action points developed thereafter.

We were pleased to hear that advocacy services had resumed face-to-face visits. Patients are referred to advocacy if appropriate. We could not find evidence of advocacy involvement in the patient files that we reviewed.

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 were pleased to hear that as a result of a previous Mental Welfare Commission recommendation, the service were able to fund an activity worker. However, the funding for this post came from existing establishment and had a negative impact on the delivery of patient care. In Spring 2022, additional funding was secured for two full-time activity support workers (ASW) for Garry and Tummel Wards. The ASWs work alongside the clinical team, patients, carers and families and developed and deliver person-centred activities on a daily basis.

Due to the nature of some of the patients' illness, their involvement in activities can be limited. We found evidence of daily recordings of activities that had been offered to patients and whether they had participated or declined. This included both one-to-one and group activities. Activities that patients were involved in included: baking groups, arts and crafts, yoga, chair based exercise, board games and relaxation sessions. During our visit, we saw a number of patients pushing prams in Garry Ward. We were pleased to hear that the ward had obtained a number of prams and these were clearly having a therapeutic and calming effect on patients.

The physical environment

Garry and Tummel Wards were identical in layout and both consisted of single en-suite rooms. The bedrooms had information about the patient on the bedroom door to help orientate them. It would be beneficial if the information was enlarged and placed just below the patient's eye line. Patients also had a memory box attached to their bedroom door. In their bedrooms, patients had 'This is Me' information on the wall that supported them when moving on. This was an A3 poster that was developed in collaboration with patients and their relatives or carers to allow staff to learn more about their patients and their needs. Patients' bedrooms

were locked during the day however they could ask nursing staff to unlock them if they wish to spend time in them.

The wards benefitted from a number of pleasant outdoor courtyard areas that patients had access to during the day. We were pleased to hear that endowment monies will be used to completely refurbish one of shared gardens to create a dementia friendly outdoor space. This should be completed by the Autumn 2023. We look forward to seeing this during our next visit.

At the end of the corridor, in both wards, was a large screen window. Members of the public were able to see inside the ward, which raised privacy and dignity issues for patients. Previously, Garry Ward had attached Perspex stickers, however these had been removed by patients. Tummel Ward had attached a Perspex sheet that covered the lower part of the window, however it unfortunately meant that patients were unable to look out of the window.

Recommendation 6:
Managers should explore solutions to ensure patients are able to look out of the ward windows, without their privacy being compromised.

Summary of recommendations

Recommendation 1:
Managers should ensure that staff completing care plans undertake care plan training and refer to NHS Tayside's person-centred care planning standards.

Recommendation 2:
Managers should ensure that nursing staff include summative evaluations of care plans in patient notes that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 3:
Managers should ensure that patient/relative involvement in care planning is encouraged and recorded.

Recommendation 4:
Managers should ensure that MDT meetings are fully recorded including patient/relative involvement.

Recommendation 5:
Managers should ensure that where a patient lacks capacity in relation to decisions about medical treatment, s47 certificates and treatment plans must cover all relevant medical treatment the individual is receiving. Treatment should be described in full and abbreviations should not be used.

Recommendation 6:
Managers should explore solutions to ensure patients are able to look out of the ward windows, without their privacy being compromised.

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

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