Mental Welfare Commission for Scotland

Report on announced visit to:

North Ward, Dykebar Hospital, Grahamston Road Paisley, PA2 7DE

Date of visit: 14 June 2023

Where we visited

North Ward provides care for men over 65 years of age who require ongoing hospital care due to their complex mental health needs. The ward has 21 beds, all in en-suite bedrooms. On the day of our visit, the ward was fully occupied.

We last visited this service on 10 November 2021 and made recommendations for a review of staffing arrangements, an audit of the powers granted to proxy decision makers that were held on file, an environmental audit of a main sitting area with an accompanying action plan and a review of the system for managing laundry.

The response we received from the service was that a psychology, physiotherapy and occupational therapy posts had been recruited to, although recruitment to other professions remained an ongoing issue. Work was underway with the occupational therapist and art therapist to improve the environment of the day room. Action had been taken to address the issue of laundry and this was being monitored on an ongoing basis. There was a system in place to ensure copies of power of attorney (POA) documents or guardianship orders were requested on admission and this had been followed up.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision and care planning.

Who we met with

We met with and reviewed the care and treatment of seven patients and four relatives.

We spoke with the senior charge nurse, charge nurse, service manager, operations nurse manager and lead nurse support.

Commission visitors

Mary Hattie, nursing officer

Mike Diamond, social work officer

What people told us and what we found

Care, treatment, support and participation

Care and treatment

We spoke with four relatives, the majority of whom spoke positively about the ward nursing team, commenting on the warm and friendly atmosphere in the ward. One relative spoke about the importance of being confident that their relative was being well cared for in their absence and the peace of mind this gives them. However, it was highlighted to us that the staffing levels on the day of our visit were not those usually found on the ward. Several relatives commented that whilst the regular staff knew their relative well, and were very skilled at managing their distress, the ward was often short-staffed and relied on bank staff. The impact of staffing levels on opportunities to mobilise one patient was recorded in their care notes. We discussed this with the charge nurse, the operations nurse and lead nurse, who acknowledged that staff are frequently moved from North Ward due to competing clinical demands and staff shortages in acute wards. We were advised that a significant number of new staff nurses have been recruited by NHS Greater Glasgow and Clyde (NHSGGC) and that 10 of these have been allocated to Dykebar Hospital, and will be employed in September 2023. It was anticipated that this would reduce the need to move staff out of North Ward.

The ward had medical input from a consultant psychiatrist and a specialty doctor. There was dedicated psychology, occupational therapy (OT), an OT technician, pharmacy and physiotherapy input. Social work were involved on a case-by-case basis. Input from speech and language therapy, dietician, and other allied health professionals and specialist services was available by referral.

Multidisciplinary team (MDT) reviews were recorded on the EMIS electronic record keeping system. MDT notes provided a summary of recent presentation and care needs. Decisions and action required were clearly recorded, and this information was reflected in care plan evaluations. The requirement for NHS hospital care was reviewed on a regular basis.

We heard that proxy decision makers were invited to attend reviews. We noted a prompt on the MDT review template to remind staff to enable relatives to attend the MDT.

We found life history information and completed 'Getting to know me' (GTKM) forms in the patients' files that we reviewed. This is a document that contains information on an individual's needs, likes and dislikes, personal preferences and background, which enables staff to understand what is important to the individual and how best to provide person-centred care whilst they are in hospital. This, and other information gathered, was used to populate 'What matters to me', which was available in patients' bedrooms as an aide memoire to staff.

In the care plans we reviewed, risk assessments were documented and reviewed regularly. Care plans were person-centred and addressed identified risk and current needs. Care plan evaluations were regular, thoughtful and meaningful. However we found one care plan which had not been updated to reflect a change in legal status, despite this having been recorded in the monthly evaluation.

Where an individual was experiencing stress and distress, there was a detailed care plan that included information on the potential triggers, behaviours exhibited and management

strategies, which had been found to be effective for the individual; the majority of these followed the Newcastle model. This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge. The model emphasises the use of sharing information with staff to develop effective 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 continue to review the staffing levels in the ward to ensure that the staffing resource is adequate to meet the clinical needs of patients.

Recommendation 2:
Managers should audit care plans to ensure they are updated following evaluations to reflect any changes in patients' needs.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), we found copies of detention paperwork kept on file. Part 16 (s235-248) 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. Certificates authorising treatment (T2/3) under the Mental Health Act were in place where required, and authorised all treatment prescribed.

Where patients had a proxy decision-maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), this was recorded in the care file and in all the files we reviewed the certificate granting the power of attorney (POA) was kept on file or had been requested.

Where individuals lacked capacity to make decisions about their health care, section 47 certificates, which authorise treatment under the AWI Act, were in place and proxy decision makers were being consulted in relation to treatment

Rights and restrictions

The ward door was secured using a keypad entry system, and there was a locked door policy. We saw information on advocacy services on display in the ward. The ward had an open visiting policy; visitors who wish to assist their relatives at mealtimes were supported to do so.

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

There was a health care support worker dedicated to activity provision and the occupational therapy staff provided a programme of group activities. The ward activity board included a wide range of activities including breakfast and lunch groups, reminiscence work, football memories groups, music sessions, virtual therapet sessions, life history work, games etc. There was a football memories box containing football memorabilia and items that could be used for reminiscence work. The ward received regular visits from therapet and the wandering minstrel.

In care files we found good information on previous occupation, hobbies and interests, including musical preferences, and this was reflected in the activities individuals were participating in. We found regular recording of activity preference and participation in the chronological notes and saw a variety of activities happening during our visit.

The physical environment

The ward comprises of 21 single en-suite bedrooms. We noted a good level of personalisation in bedrooms, with family pictures and personal items on display. There was dementia-friendly signage throughout the ward. There was a small quiet sitting room and an activity room, both with direct access to a level garden area with covered seating. At the time of our visit the garden had recently been attended to, with new planters in place; we are advised that new garden furniture had been ordered. However, a relative had commented that this was a dreary and neglected space up until very recently.

The activity room had been thoughtfully decorated, with a bar/pub area and football memorabilia on display. We were told this room was well used for breakfast and lunch groups and various group and individual activities. During our visit we saw a football group taking place, and the room was used for visitors later in the day. On the corridor walls, there were a number of activity boards and pictures of sporting celebrities and local scenes. The main sitting area sat at the crossroads of the corridors in the central hub of the ward, with a number of bedrooms off this area. As a result, this was a busy thoroughfare. Natural light was provided by a skylight however, there were no windows in this area. Despite the work undertaken to improve the environment with murals, and a screen showing an aquarium and other scenes this remained a gloomy and uninviting space for patients, some of whom spent a considerable amount of their day there and is not fit for purpose.

The bathroom in the ward was upgraded some years ago with the doors widened to accommodate a hoist. However, the room was small, the space around one side of the bath was very narrow, making it difficult and possibly unsafe for staff should they have needed to assist a patient from this side. In one GTKM form we reviewed it stated the patient preferred a bath, however on reviewing the notes we could find no evidence that this preference was met. We were advised by staff that it is not possible to transfer a patient from a wheelchair into a hoist in the space available, and as a result, the bath is rarely used with most patients having showers. This would seem to go against their preferences in the GTKM information that relatives had provided regarding their relative's care.

Recommendation 3:
Managers should undertake a safety and environmental audit of the ward, with special focus on the day/dining space and the bathroom to ensure it is fit to meet the needs of the patient population.

Summary of recommendations

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Recommendation 2:
Managers should audit care plans to ensure they are updated following evaluations to reflect any changes in patients' needs.

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Managers should undertake a safety and environmental audit of the ward, with special focus on the day/dining space and the bathroom to ensure it is fit to meet the needs of the patient population.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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