Mental Welfare Commission for Scotland

Report on announced visit to:

Inverclyde Royal Hospital, Wards 4 A & B, Larkfield Unit, Larkfield Road, Greenock, PA16 0XN

Date of visit: 11 July 2023

Where we visited

Ward 4 was located on the first floor of the Larkfield Unit, which is part of the district general hospital. The unit had 20 beds for the assessment of older people and was designated as short stay. The ward was divided into two sub-units; 4A provided 10 beds for people with dementia and 4B provided 10 beds for people with other mental illnesses. At the time of our visit, there were nine patients in 4A and seven in 4B, two individuals were on enhanced observations.

We last visited this service on 7 July 2022 and made recommendations in relation to the recording of multidisciplinary team meetings (MDTs), life history information and 'Getting to know me' documentation, care planning, with particular reference to stress and distress, and activity. We also made recommendations relating to treatment under the Adults with Incapacity (Scotland) Act 2000 (AWI Act). The response we received from the service was that action had been taken to address all of the issues highlighted, and an action plan setting out actions taken was provided.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at the development of activity provision and links with the community. This was because on our last visit the service was in the early stages of re-engaging with community supports and volunteers.

Who we met with

We met with and reviewed the care and treatment of eight patients, as well as one former patient and one relative.

We spoke with the service manager, the senior charge nurse and members of the nursing team

Commission visitors

Mary Hattie, nursing officer,

Anne Craig, social work officer

Douglas Seath, nursing officer

What people told us and what we found

Care, treatment, support and participation

The ward had recently recruited a new locum psychiatrist who provided four sessions per week and held weekly multidisciplinary (MDT) meetings. A link social worker had been allocated to attend MDT meetings and it was hoped that the new pharmacist would also attend. There was also regular input from psychology, occupational therapy, and physiotherapy. A paper had been submitted to increase the physiotherapy input to address the inequity of provision across services. Input from other professionals, including dietetics and speech and language therapy, was arranged on a referral basis. Nursing staff levels had been amended and increased; the compliment of band six nurses had risen to three and interviews were due to take place to appoint to the two vacant posts. Two new band five nurses were due to take up post, however bank and agency staff were utilised during periods of increased clinical activity.

Multidisciplinary (MDT) meetings

We were pleased to find that MDT meetings were being recorded using the MDT template, however the quality of recording of these meetings was inconsistent, with a significant percentage of meeting records not containing information on who was present. The level of detail provided in relation to decisions made and the rationale for this varied considerably.

Recommendation 1:
Managers should audit MDT notes to ensure these contain a record of those present, detail of the decisions taken and a clear action plan.

Family involvement

We found limited recording of family involvement in the chronological notes. Families were not routinely invited to reviews. In a number of files we reviewed, reference was made to family meetings having been arranged, followed by a single sentence outlining decisions agreed, however there was no record of the content of the meeting. A relative told us “the majority of staff in this ward are great, and there is one who deserves a gold medal, as she always lifts everyone’s spirits”.

Recommendation 2:
Managers should undertake a review of the process for involving families and consulting proxies and ensure that family and proxy involvement is fully documented.

Care plans

We were pleased to find completed ‘Getting to know me’ documentation on file for all the individuals we reviewed. This is a document which records a person's needs, likes and dislikes, personal preferences and background, aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. We had previously recommended that ‘Getting to know me’ be completed and life history information recorded in patients’ files. Whilst there had been considerable improvement in the completion of “Getting to know me” since our last visit, we could not find any evidence of life history information being collated and recorded in the files we reviewed. This information is important in helping staff deliver person-centred care, given the significant proportion of patients who

move on to further care placements; we feel this should be collated and recorded as part of the assessment process. We were pleased to see completed 'What matters to me' documentation held at the bedside for all the patients in the ward. This was a simple one page document that highlighted information that is important to the care of each patient; this can include practical information such as the need for hearing aids, glasses, walking aids, as well as personal preferences and dislikes.

We reviewed the files of a number of patients who were prescribed as required medication for agitation, or were on enhanced levels of observation; however, only one individual had a Newcastle formulation and detailed care plan. The Newcastle model is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. For the other patients we reviewed, there was no care plans for the management of their stress and distress; the patients' agitation was referred to in the mental health care plan, and reference was made to using "stress and distress techniques". If this was unsuccessful medication was to be used, but there was no detail around the nature of the distress, potential triggers or how this might have been managed. It is essential that, where an individual suffers from stress and distress, a care plan is developed that identifies the potential triggers for the individual and identifies how this may be managed to ensure the safety and wellbeing of both patients and staff.

Risk assessments were reviewed regularly and we found regular care plan reviews documented that contained meaningful information about the patients' progress and changing needs. However, a care plan we reviewed had been written shortly after admission and had not been updated to reflect changes in care. The care plans were not person-centred; they lacked information about the needs, treatment goals and interventions for the individual patient.

We had made recommendations in relation to the quality of care planning in our last two reports and in our last report had made a recommendation that practice development nurse support should be provided to the nursing team to address these issues. However, we were advised that, due to movement and vacancies in the senior nursing team, this support had not been offered. Care planning is an integral part of patient care and the Commission expects to see appropriate person-centred care plans in place for each patient. We recommend urgent action be taken to address this issue.

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 3:
Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement.

Recommendation 4:
Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on each individual's triggers

and strategies, which are known to be effective for distraction and de-escalation and be regularly reviewed.

Recommendation 5:
Managers should undertake regular audits of the care plans to ensure these are person-centred and updated to accurately reflect the patients' current needs and planned interventions.

Recommendation 6:
Managers should, as a priority, address the training needs of the nursing team and provide dedicated practice development nurse support alongside line management support to the ward to ensure that the above recommendations are implemented.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA), copies of detention paperwork were 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. All treatment was in keeping with the Mental Health Act.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), this was recorded and all of the files we reviewed contained copies of the powers held by the proxy. We were advised that AWI documentation is now being scanned by medical records and filed in the EMIS electronic record, as well as being held in ward-based paper files.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Acr must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found completed section 47 certificates and treatment plans in the notes of all the patients we reviewed who lacked capacity; consultation with proxy decision makers had been recorded.

Rights and restrictions

The ward doors were secured by a keypad entry system. Visitors exited and entered with the assistance of nursing staff. There was information about this on display. Person-centred visiting was supported, with core visiting times in the afternoon and in the evening, however visits out with these times could be arranged. In the dementia unit, the communal day/dining facility was not accessed by visitors; visiting took place in patients' bedrooms or the small quiet sitting room.

The ward had access to advocacy, and details of the service were on display on the notice board.

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

The ward had input from an occupational therapist, an occupational therapy assistant and a patient activity co-ordinator who provided a range of therapeutic and recreational activities on a one-to-one and group basis. The patient activity co-ordinator provided input two days a week. Nursing staff advised us that they engage in informal activities on an individual and small group basis however we found very little information on activity participation recorded in the chronological notes. The ward also had input from a physiotherapist who provided an exercise class and patients who wish it could use the gym in the Argyll unit. There was an activity board giving information on the activities planned for the week, and we saw patients participating in activities during our visit. Access to a range of face-to-face external supports was being re-introduced, with the Clydeside Singers having visited recently; attempts were being made to secure regular therapet visits again.

We had previously made a recommendation in relation to the need to ensure activity care plans were person-centred. On this visit, whilst we found activity care plans in most of the files we reviewed, these were not person-centred and had not been updated to include information on each individual's previous hobbies or activity preferences, which had been recorded in the care plan evaluations.

Recommendation 7:
Managers should audit activity care plans to ensure these include person-centred information about the individuals' hobbies, skills and interests.

Recommendation 8:
Activity participation and outcome should be recorded in patients' chronological notes, managers should ensure this is done for each patient.

The physical environment

The ward is on the first floor of the Larkfield Unit. There was a pleasant secure courtyard garden, however as this could not be accessed directly from the ward, patients could only access this with staff support. Staffing levels and clinical activity limited when this could be facilitated. We heard that the possibility of a move to a ground floor ward with direct garden access had been explored, however even factoring in a small reduction in bed numbers, the accommodation available on the ground floor was not large enough or suitably configured for the needs of the patient group.

Beds were provided in a mixture of single en-suite rooms and small dormitories. In 4A, the dementia unit, there was one large communal sitting, dining, and activity area. This could become noisy at times, which could be distressing for some patients. The dining and sitting areas in 4B are separate. There was dementia-friendly signage throughout the unit. The ward was clean, however the décor was rather drab and clinical; there was no evidence of personalisation around bed spaces. We were told that redecoration, which has been delayed due to Covid-19 restrictions, will not now be undertaken until midway through 2024 as it will be necessary to decant the ward to another setting to allow the work to be undertaken.

Any other comments

We were advised by both a relative and a former patient that they had experienced a significant number of items of personal clothing having been lost in the laundry system. It was confirmed by nursing staff that despite the best efforts of staff to ensure that personal laundry is kept separate and bagged appropriately losses have been occurring.

Recommendation 9:

Managers should undertake a review of the current system for managing personal laundry.

Summary of recommendations

Recommendation 1:
Managers should audit MDT notes to ensure these contain a record of those present, detail of the decisions taken and a clear action plan.

Recommendation 2:
Managers should undertake a review of the process for involving families and consulting proxies and ensure that family and proxy involvement is fully documented.

Recommendation 3:
Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement.

Recommendation 4:
Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on each individual's triggers and strategies, which are known to be effective for distraction and de-escalation and be regularly reviewed.

Recommendation 5:
Managers should undertake regular audits of the care plans to ensure these are person-centred and updated to accurately reflect the patients' current needs and planned interventions.

Recommendation 6:
Managers should, as a priority, address the training needs of the nursing team and provide dedicated practice development nurse support alongside line management support to the ward to ensure that the above recommendations are implemented.

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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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