Mental Welfare Commission for Scotland

Report on unannounced visit to: Muirton Ward, Seafield Hospital, Buckie AB56 1EJ

Date of visit: 28 June 2023

Where we visited

Muirton Ward is an older adult assessment unit for people with dementia. The ward had eight beds although on the day of our visit, there were nine patients on the ward, and one on pass. The senior charge nurse (SCN) told us that the ward had to recently use two surge beds due to the mental health unit at Dr Gray's Hospital being at full capacity.

We last visited this service on 10 May 2022 and made recommendations about auditing patients' notes, activity provision and the outdoor space. We received an action plan from the service and were satisfied as to how the service had planned to address those recommendations.

On the day of this visit, we wanted to follow up on the previous recommendations and speak with patients, relatives and staff.

Who we met with

When we plan a visit, prior notice is given to patients and relatives of our intention to visit. Given that this visit was unannounced, we were unsure if we would have the opportunity to speak with relatives, however we managed to speak with one relative and we reviewed the care and treatment of five patients.

We spoke with senior charge nurse (SCN), ward staff, the consultant psychiatrist and the lead nurse.

Commission visitors

Tracey Ferguson, social work officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit, we introduced ourselves to all the patients and chatted to them throughout the day. We were not able to have in-depth conversations with all the patients in the ward because of the progression of their illness, however some patients were able to tell us that "staff were nice and lovely" and some told us that they were "happy" on the ward.

A few patients described the food as "very good" whilst some patients told us that there was not much to do on the ward. Where we were able to have more detailed conversations, patients were able to tell us about their treatment and what they wished to have happen. One patient spoke about wanting to go home, but was unsure about what was happening as there had been talk of them going to a care home; we had further discussions with the SCN about this individual's rights. Another patient was able to tell us about the plans to get them home and the support that was required.

From our observations, the ward had a relaxed atmosphere and patients appeared settled. Where there was evidence of stress/distress behaviours, we saw nursing staff responding in a supportive manner.

From speaking to the ward staff, we were able to gain a sense that they knew the patients well and were able to provide us with a comprehensive update in relation to patients' care and treatment. The relative we spoke with described staff as "excellent" and "very approachable" and told us how nursing and medical staff provided them with regular updates. The relative told us that there was flexible visiting times that enabled them to be involved and feel part of their relative's care and support.

The ward had devised a relative information pack that was handed out following admission to the ward. The pack provided relatives with detailed information that covered a wide range of topics such as carer support, patient's rights, visiting times, laundry and discharge planning.

Care planning

In patients' files we found nursing and risk assessments that were detailed and that had been completed on admission. The ward staff completed an SBAR (situation, background, assessment and recommendation) document that provided a clear account of the patient's history and the circumstances that led to the admission, along with the next steps that were required to support the patient in their journey. In each file, we saw 'Getting to Know Me' booklets that had been completed by patients and relatives, and these gave an informative account of the patient's life history.

The ward had a named nurse system in place and for this visit, we wanted to review the progress that had been made in ensuring that care plans were updated and reviewed, and had meaningful evaluations. We noted that work was ongoing in relation to care plans, reviews and evaluations and we found that progress had been made since our last visit, which was positive.

We found evidence of detailed person-centred care plans that addressed the mental health and physical health needs of the patients, and evidence of care plans being reviewed and updated where necessary; most of them included a meaningful evaluation.

We wanted an update of the audit process that we had been advised was now in place. The SCN told us that there was a regular audit system; we were provided with examples and outcomes of recent audits. We provided some feedback, as there were a few areas that we felt the service could improve upon as part of the audit process. We advised that evidencing carer/patient involvement could be improved, as a number of the care plans that we reviewed recorded 'patient unable to sign due to mental state'. Although we had been told that involvement was encouraged, we discussed ways in which the SCN and lead nurse could evidence this.

There was good evidence of one-to-one sessions with nursing staff that were recorded in the notes; these were detailed and gave a good account of the patient's views.

Multidisciplinary team (MDT)

There were two consultant psychiatrists that covered the ward and we were told that multidisciplinary meetings (MDT) took place weekly and that the ward had access to allied health professionals (AHP's) and psychological services via a referral system. We found there was a clear focus on both physical and mental health care, and that this was recorded in the patients' records, along with regular monitoring.

We saw the weekly MDT record in patients' notes that recorded who was present at the meeting, along with patient updates/progress, completed by nursing staff and the recording of action/outcomes from this meeting. We were told that patients and relatives do not attend the weekly meeting, however there were MDT meetings arranged with relatives and patients at regular intervals throughout an admission. We saw recordings of these meetings along with discharge planning meetings. The consultant told us that they were available to discuss patient care and treatment with relatives over the phone, or when the relative requested an update. We heard that they would speak with patients regularly throughout each week, as some patients may not be able to sit in a meeting due to their presentation.

The SCN told us that there was weekly contact with social work to discuss and obtain updates on the progress of discharge planning and we viewed evidence of this in patients' files. We asked the SCN about patients who were recorded as delayed discharge. We were told that there were two patients whose discharge from the ward was delayed; we saw from the files that there was active planning and follow up being done to support the patient to move on from hospital. We were aware from other recent visits that NHS Grampian were operating two lists, a delayed discharge list and a delayed transfer of care list. We will continue to have discussions with senior managers regarding these lists, in an effort to understand how they are being managed.

Use of mental health and incapacity legislation

On the day of our visit, four patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Where patients were subject to detention under the Mental Health Act, we found that the paperwork was in order, along with the authorising treatment forms (T3) completed by the responsible medical officer (RMO) to record non-consent, apart from one patient. We discussed this further with the RMO on the day.

Since our last visit, we have continued to follow up with managers of NHS Grampian and the health and social care partnerships (HSCP) our concerns around the usage of intramuscular medication (IM) which we have highlighted in previous visit reports. We have had follow up meetings, provided advice and good practice guidance to the managers. We are continuing to follow up on this matter, as we are aware that NHS Grampian is in the process of reviewing their rapid tranquilisation policy and we would expect to see this good practice guidance incorporated into the policy. Since our last visit, the SCN informed us that the use of IM medication has not been administered or prescribed for patients who have not been detained under the Mental Health Act. The SCN and lead nurse told us about the process that is in place if there was concerns about a patient's presentation. We were told that the patient would be assessed by a doctor and consideration given to the use of Mental Health Act legislation.

For patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000(AWIA), copies of the legal orders were in place.

On reviewing patient's notes, we were pleased to see a checklist form that staff used to record specific legal orders that patients were subject to under AWI Act legislation. However, we found a few entries that were unclear as to the particular section of the AWI Act that the patient was subject to. We found that there were entries that simply recorded "AWIA in place". We brought this to the attention of the SCN on the day, as we considered this lack of detail and clarity could lead to confusion amongst clinical staff.

The ward had a display board in the staff office that provided an overview of all patients in the ward and recorded their legal status. We were pleased to see that it clearly recorded the specific section of the AWI act on the board. We had a further discussion with the SCN about the audit tool used in the ward, as this also had recorded "is there an AWI in place".

The Commission had published the *Authority to Discharge* report in May 2021, where concerns had been raised about moves from hospital to care homes for people who lacked capacity, and also found there was lack of understanding by professionals around the AWI law, including misunderstandings about power of attorney (POA). We had a further discussion with the SCN about the audit tool and mental health act checklist and how these could be amended to the reflect whether or not a patient's POA was activated. The Commission is continuing to follow up on the recommendations with health boards and health and social care partnerships (HSCPs). The report can be found here: https://www.mwcscot.org.uk/node/1569

We wanted to review treatment certificates that were in place and we reviewed all AWIA section 47 certificates and treatment plans. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan under section 47 of the Adults with Incapacity (Scotland) 2000 Act (AWI) 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, who has relevant powers and record this on the form.

We found some s47 certificates that were detailed and completed in accordance with the AWI code of practice for medical practitioners. However, we discussed one certificate with the RMO and SCN, as the patient had been assessed as having capacity and therefore this certificate was no longer required. We brought this to the attention of the SCN and requested that the care plans were updated to reflect this change.

Rights and restrictions

The ward had a locked door policy in place that was commensurate with the level of risk identified with the patient group. The ward continued to have good links with Circles Network advocacy service, who regularly visited patients on the ward, and support patients with their rights. We had a discussion with the SCN and lead nurse about patient's rights, where there was no detention in place. The ward had the Commission's *Rights in Mind* pathway displayed on the wall in the ward corridor and in the relatives' information pack, which we were pleased to see.

Where covert medication pathways were in place, we saw appropriate documentation, including detailed reason for the need to use this along with appropriate review.

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 looked for evidence of activity planning in patients' files and wanted to see if activities were linked to patient goals. Therapeutic activities are important to support patients with their stress/distress symptoms and we heard from staff about the benefit and focus of activities. However, although there was some reference made in the file about activities, there was a lack of regular activities happening for patients across the ward. We heard that due to the demands on nursing tasks, this had an impact on the delivery of activities. We heard from a few patients that there was not enough to do to keep them occupied, and we gained a sense that patients wanted more to do to keep them occupied.

On our previous visit to the ward in 2020, the ward recorded patient activities in a separate folder and had a dedicated activity room. We were told that this room had to be used for other means during the Covid-19 pandemic and we were advised on our visit in 2021 that the activities were no longer recorded separately in the folder; at that time, we were concerned about the lack of regular activities that were taking place on the ward.

The ward no longer had a dedicated activity coordinator/therapist to plan and co-ordinate group or one-to-one activities and we had the same concerns from this visit about the lack of regular activities that were taking place and that had been planned for the patients.

Recommendation 1:
Managers should consider the appointment of an activity coordinator/therapist.

The physical environment

The ward was an older-style dormer ward that was spacious, with a corridor that led to single rooms and shared dormitories. Dementia-friendly signage was on display throughout the ward, which helped patients to find their way around the ward. Each dormitory had access to a shower room and toilet. The ward had a number of sitting areas for patients and ample space for patients who preferred to wander. On the day of the visit, we saw patients freely walking up and down the corridor.

One of the dormitories had been used as an activity room, however this been used as a storage space since the Covid-19 pandemic and was still being used in the way on this visit.

There was a separate dining area along with a seating area. The ward had another quieter lounge that relatives often used, and there was a large enclosed conservatory with access to an enclosed garden.

We wanted to follow up on our last recommendation regarding the outdoor space and we were pleased to see that the outdoor area had been repaired and was accessible for patients. The SCN told us that the friends of Seafield Hospital had funded the work and volunteers from Finechty Men's Shed carried out some of the outdoor work.

The Commission was aware that there were ongoing discussions with Moray HSCP and NHS Grampian about the works that were required for Ward 4 Dr Gray's Hospital. We had been informed that a decision had been made for Ward 4 to be decanted to Muirton Ward and that the plan was for Muirton Ward to decant to another area on the Seafield Hospital site. We were aware of ongoing discussions with this, and the works that would be required to ensure the environment was suitable for people with dementia.

We will continue to ask for updates from the chief officer of Moray HSCP.

Other comments

Since our last visit, the ward has had a few changes in the leadership team and there was a new SCN in post. This new appointment had provided the ward with the leadership and continuity, along with improvements, which was positive to see.

The Commission has continued to link in with HSCPs regarding the recommendations from the *Authority to discharge* report to ensure that these are being met, therefore it was important that the lead nurse liaised with the HCSP about identified training gaps so there was a collective approach in moving forward to better enhance the workforces knowledge base.

The Scottish Government provided funding to develop an Adults with Incapacity framework for staff and this has continued to progress jointly with the Commission and NHS Education for Scotland (NES). We will keep the HSCPs and NHS Grampian appraised of this development as this will only continue to enhance the knowledge base of staff when working and supporting people subject to AWI legislation.

Summary of recommendations

Recommendation 1:
Managers should consider the appointment of an activity coordinator/therapist.

Service response to recommendations

The Commission requires a response to this recommendation 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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