Mental Welfare Commission for Scotland

Report on announced visit to: Clonbeith Ward, Ailsa Hospital, Dalmellington Road, Ayr, KA6 6AB

Date of visit: 8 November 2023

Where we visited

Clonbeith Ward is a 12-bedded ward in the Ailsa Hospital Campus in Ayr; the ward is designated for the continuing care of adults with a diagnosis of dementia. On the day of our visit, there were 10 patients with complex, stressed and distressed behaviour. Clonbeith is one of the few remaining wards on the Ailsa Campus. Most of the others have transferred to Woodland View Hospital in Irvine. We were keen to hear about the impact that this has had on service delivery, if there have been any changes to ward resources, and whether staff feel sufficiently supported to deliver care and treatment to a high standard. We last visited this service in May 2021, and made no recommendations.

On the day of this visit, we wanted to review the care and treatment being received by patients. We also wanted to find out if there had been progress made towards the development of psychology services to the ward, the development of the garden area and the impact of the introduction of a care planning champion and an activity co-ordinator to the ward.

Who we met with

We met with, and reviewed the care of six patients, who we met with in person and reviewed the care notes of. We also met with, and heard from, two relatives.

We spoke with the service manager, the clinical nurse manager, the two deputy charge nurses, and members of the nursing team.

We also met with a volunteer who regularly attends the ward to support activity provision.

Commission visitors

Mike Diamond, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

All patients and relatives that we met with during the visit spoke positively about the care and treatment provided by staff in the ward. We heard specific comments about staff being approachable and friendly, with one individual stating the nurses were 'amazing'. We observed positive interactions between staff and patients during the time we spent on the ward. The staff told us of the strong team they feel they have, which they believe contributes to the care and treatment received by the patients. We also observed strong nursing leadership that contributed to each patient's experience on the ward and positive outcomes in terms of care and treatment. We spoke to staff throughout the day and we were able to see that the staff team knew the patients extremely well. There was a sense of commitment and enthusiasm in the staff group that was evident through speaking with the staff and watching their interactions with the patients. One relative let us know they felt their loved one was more content and relaxed since being admitted to the ward and described staff as ''helpful and caring''.

We heard from the service about a significant piece of work that they had completed to improve the quality of care plans. This included specific care plan training for all registered nurses, and the training was based on the Mental Welfare Commission good practice guidance on person-centred care plans. We found evidence of the impact of this initiative when we reviewed the electronic notes for patients, though some staff were still to receive training.

Information on patients care and treatment is held on Care Partner. We found this easy to navigate. We mainly found detailed person-centred care plans that evidenced care and, where possible, patient involvement. It was good to see that discharge care plans were in place. We found the care plans were regularly reviewed and evaluations were summarised in the new care plan, allowing the reader to understand what progress had been made and to assess the value of previous interventions. We noted that the Ayrshire Risk Assessment framework was embedded in practice. Individualised plans were reviewed and regularly updated. We saw that physical health care needs were being addressed and followed up appropriately.

There were excellent examples of anticipatory care plans; these were mostly used to support people living with long term conditions to plan for an unexpected change in health. The care plans evidenced the evolving conversation, collaborative interactions and shared decision making between patients, families and the multidisciplinary team (MDT).

Care records showed regular interactions and one-to-one meetings with individuals and their families. Where families were unable to come into the ward, we saw detailed records of phone conversations to ensure relatives were kept updated.

Multidisciplinary team (MDT)

The documentation of the MDT meeting was detailed and provided a clear record of those in attendance. We did note the patient and their families did not appear to attend the ward reviews but were present, where appropriate at the six-monthly main review. We discussed this with staff on the day and were informed that patients and carers were welcome to attend the more regular meetings, but most chose to only attend the main review. The consultant psychiatrist attends the ward for review meetings weekly, and there is a speciality doctor who is available to review patients and who manages day-to-day medical concerns.

We were told that the service can refer to occupational therapy, physiotherapy, dietetic or social work, but there is no dedicated time from these professionals on the ward; the services are based at the Woodland View campus. There was evidence in the notes that these professions were regularly involved in the care of patients in Clonbeith Ward and staff reported there is a prompt response to referrals.

A psychologist has recently been appointed and now has dedicated time for the ward. We heard how the addition of a comprehensive clinical psychology assessment and intervention plan, particularly in relation to stressed and distressed behaviour, has been beneficial. The psychologist also provides supervision and reflective practice for the staff team.

Each individual's own social worker attends review meetings as required, and any delayed discharges are discussed at the two-weekly pan-Ayrshire meeting which involves the hospital social worker, representatives from the three health and social care partnerships and the care home liaison nurse. Information from these meetings is fed back into the review meetings and included in each individual's discharge care plan. We were pleased to hear about this proactive approach to delayed discharges, as there were three individuals waiting for care home placements having been assessed as fit for discharge on the day we visited. There was clear evidence in these individuals' notes about the actions taken to try to secure an appropriate placement for them.

Use of mental health and incapacity legislation

We heard that the service had developed a LearnPro module to support staff in the application of the Adults with Incapacity (Scotland) Act 2000 legislation. The service had also developed an electronic initial patient profile page. This has created a flag on the system to ensure that staff could easily see when a legislative framework was is in place for an individual.

On the day of our visit, one patient in the ward was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (the AWI Act), including certificates around capacity to consent to treatment, were in place in electronic files and were up-to-date.

In relation to the AWI Act, where the patient had granted a power of attorney (POA) or was subject to guardianship, we found information confirming this and contact details for the proxy decision maker were provided. Copies of the powers were available in all the files we reviewed and there was evidence throughout the chronological notes of consultation with proxy decision makers in relation to care and treatment.

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, but in one case, a T3 certificate did not correspond to the medication being prescribed. We highlighted the instance where medication was prescribed but not included on the T3 certificate on the day and requested the responsible medical officer update this as a matter of urgency. We found that other T3s had been completed by the responsible medical officer to record non-consent, and were available and up-to-date. We also found when reviewing drug prescribing sheets that an informal patient had been prescribed an intramuscular (IM) anxiolytic medication to help manage agitation.

Recommendation 1:
Managers should audit authority to treat documentation and drug prescriptions to ensure that all treatment is legally authorised.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor (or another healthcare professional who has undertaken specific training). The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We noted s47 certificates and treatment plans were in place in the patients files we reviewed on the day. Where patients had a proxy decision maker appointed under the AWI Act, this was not recorded in one case. This was discussed with staff on the day and requested that medical staff ensure this discussion is recorded on the certificate.

For patients who had covert medication in place, all appropriate documentation was in order, and the pathway where covert medication was considered was completed appropriately and review dates were clearly recoded. The Commission has produced good practice guidance on the use of covert medication at:
https://www.mwcscot.org.uk/node/492

Rights and restrictions

On the day of our visit, there were two patients that required a higher level of staff support with continuous intervention. There was recognition from the senior leadership team that whilst continuous intervention, to support patients during acute phases of distress and illness, is at times necessary, it can be considered a restrictive practice and there was an appropriate care plan in place. Continuous interventions were used only as needed by these two individuals and there was flexibility with this approach.

Clonbeith Ward operates a locked door policy and access and egress to the ward is based on individual risk assessments. On the day of our visit, we noted that while there was notification that the door was locked for safety and security at the entrance to the ward, the locked door policy was not on display. We discussed this on the day and were informed that staff will ensure the policy is displayed in the ward area. This is not possible due to the nature of the group of patients but the full policy has been placed in the relatives' room.

We found individual risk assessments did not consistently document the assessment of each individual's wish to remain in the ward environment, and we discussed this with staff on the day that this needs to be clearly documented in the MDT review.

Lap straps were found to be used at times in the care and treatment of two individuals, with their use being included on the s47 certificates. On discussion with staff and reviewing the care plans it was evident these straps were being used to minimise the risk of falls with harm and nursing staff were present when they were in use. We discussed with staff the need to ensure care plans clearly demonstrated the restrictive nature of this intervention and the mitigations that should be put in place to protect the person. We also suggested that consideration should be given to applying for appropriate legal authority for the use of the lap straps through a welfare guardianship order.

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 heard from staff how the Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) tool, an all-in-one touch screen solution that offers digital reminiscence therapy, has been introduced very successfully into the ward. It is a relatively new tool in the field of nursing and healthcare; it encompasses the use of user-friendly interactive screens and tablets to blend entertainment with therapy and to assist patients, particularly those with memory impairments, in recalling and sharing events from their past. Their memories are accessed through listening to music, watching news reports of significant historical events, listening to wartime speeches, playing games and karaoke and watching films. Staff report that even those individuals with significant cognitive impairment appear to benefit from using RITA and will show some recall and enjoyment from using this tool.

We discussed, that historically there had been an identified nurse who had the role of ward-based activity coordinator. The ward no longer provides this dedicated role and patient activities were the responsibility of all ward staff. Staff feel this helps improve communication and encourages staff to spend therapeutic time with the patients on the ward. The ward is supported by a volunteer who attends two days a week and supports attendance at activities. There are good links with the community group Centre Stage, who run regular dementia-friendly days. Ward staff support individuals to attend these sessions and we heard from one lady how much she enjoyed attending the choir sessions as there was ''nothing like a good sing for making you happy''. The staff team have recently been nominated for an award along with the volunteer for the work they have been doing in this area.

The physical environment

Clonbeith Ward is a newly refurbished ward. The ward is modern and pleasant with good natural light and the use of pictures, lighting and other items to personalise space, all of which contributed to a pleasant atmosphere. The visitors' room was well furnished and comfortable. Bedrooms were personalised with photos and belongings and efforts have been made to make them as comfortable as possible. There were also memory boxes to assist patients find

their bedrooms and signage to assist with orientating patients to the ward environment. We noticed a couple of broken or missing items when we visited, and when this was raised with staff on the day, we were assured these would be attended to.

On our previous visit we noted the garden area could be hazardous to patients if unaccompanied. We found work had been undertaken to level areas in the grounds and install ramps and raised beds to accommodate those with mobility difficulties. Staff let us know this area was well used in the warmer weather and there had been ward events held in the garden.

Summary of recommendations

Recommendation 1:
Managers should audit authority to treat documentation to ensure that all treatment is legally authorised.

Good practice

We were told about a recent quality improvement project undertaken in the ward that focussed on falls prevention. This work has resulted in a 50% reduction in falls with and the team received a highly commended award at the Mental Health Nurse Forum (Scotland) awards. As part of the work all nursing staff receive falls prevention training, and all trained staff receive training in falls management planning. A senior charge nurse was released to deliver falls prevention and care planning training to all staff. This nurse will review any patients that ward staff are concerned about or have had frequent falls and will support the trained nurses to develop a falls prevention plan. Staff have also linked this work with the introduction of RITA and feel the increase in therapeutic activity and how this activity can be included in the falls plan shows real benefit for patient safety.

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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