Mental Welfare Commission for Scotland

Report on an announced visit to: Cree Ward, Midpark Hospital, Banked Road, Dumfries, DG14TN

Date of visit: 18 July 2024

Where we visited

Cree Ward is a 16-bedded unit, situated in the grounds of Midpark Hospital. It is a specialist acute assessment unit for people with actual or suspected cognitive impairment as a result of dementia. The ward supports individuals from all localities in Dumfries and Galloway for inpatient assessment and treatment.

We last visited this service in April 2022 as an announced visit and made no recommendations.

Who we met with

On the day of this visit there were 14 individuals in the ward. We met with five individuals and reviewed their care records. We also met with one relative who was visiting the ward on the day of our visit.

We had the opportunity to speak with a range of staff who were part of the care team. We spoke with the service manager, the senior charge nurse (SCN), the consultant psychiatrist, the occupational therapist, the clinical psychologist, the clinical director, and several members of the nursing team.

This provided us with a good overview of the service delivery in the ward.

Commission visitors

Mary Leroy, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

During our visit to Cree Ward, we met with the recently appointed SCN to the service; she shared with us her previous nursing experience and her vision for the development of the service.

We met with a committed and enthusiastic staff group who were keen to progress developments in their service and who held the individual at the core of the delivery of care. Nursing staff were motivated, and they told us how they enjoyed working in the ward. They knowledgably answered all queries that we had on the day.

The individuals we met with on the day struggled to offer verbal feedback on how they felt about the care and treatment they were receiving; this was due to the level of cognitive impairment they were experiencing. One individual was able to discuss his experience of the ward commenting “it’s all right here; I have no complaints.” He also described having good contact with his family “who visit me regularly.” Another individual commented that “I enjoy it here. The people are switched on to what’s happening. If there are any problems, they deal with them. They are particularly brilliant.”

A relative stated that “the clinical team were approachable and helpful but coming to terms with a diagnosis of dementia for a loved one was difficult”.

We saw good evidence of the implementation of the triangle of care, a model of working collaboratively between the individual, professional and the carer. The model supports safety, recovery and sustains wellbeing.

In chronological notes we saw evidence of excellent communication between family and proxy decision makers. In the multidisciplinary meetings (MDT) there was evidence of family attendance and involvement in the individual’s meetings.

For some families, where there had been recent diagnosis, there was evidence of supportive communication, or counselling should the family wish to access and engage in this.

Care, treatment, support, and participation

Having spoken with individuals and relatives, we reviewed records of care in the ward. NHS Dumfries and Galloway have adopted the MORSE electronic patient record solution for use in Midpark Hospital. The clinical team have been trained in using this new system, which has been live since January 2024.

We reviewed care plans and focussed on the nursing care planning process. This was an area that had been discussed at our last visit and one where the service had planned to make improvements and that it wanted to further develop.

We discussed and considered the value and the need to capture the individual's social history. During the visit we found 'Getting to know me' documentation. This information and document was not always completed. We saw well completed documentation on 'What matters to me.' We did find relevant life history information well documented in initial assessments and in the formulation component of the Newcastle model. The Newcastle model is a framework and a process to help the clinical team understand and develop care for individuals who may present with behaviours that challenge.

We heard from the SCN of the plans for the service to further develop the 'What matters to me' documentation and process. The SCN stated that the team want to develop the use of the communication boards in each person's bedrooms and to have memory boxes. The boxes would be situated outside each person's bedroom and would have information that was important to the person placed inside. This can aid "wayfinding" and recognition and allows individuals living with dementia to navigate and identify spaces easily.

On review of the initial assessments and risk assessments, we found that the information provided comprehensive, person-centred care plans that were regularly reviewed and updated to reflect any changes in needs and of the care delivery. We found care plans to be of a good standard with a clear focus on mental health and physical wellbeing.

We noted that the risk assessment template had not yet been uploaded to the MORSE system and was held on another platform, Forms Stream.

We reviewed the files of some individuals who experienced stress and distress, where the Newcastle framework was being used. For those individuals we found detailed formulations along with the care plans for managing behaviours associated with stress and distress, as well as clear information on what may 'trigger' the individual, and the interventions and strategies that would support the person.

We also heard from both the SCN and clinical psychologist on the service plans to embed this model into practice.

Care records

Information on individual care and treatment was held on "MORSE", the electronic record system.

Templates had been created to ensure that accurate information was captured during every meeting, which supported cross-team communication. There was also a plan that all documentation would be held on one system ensuring information sharing on the safety and wellbeing of the individual.

We discussed with senior staff the long-term plan for all patient records to be held on MORSE. Senior managers informed us that the migration of the documentation is being reviewed at present and they would update the Commission on the progress of these plans.

Multidisciplinary team (MDT)

The ward has regular input from psychiatry, psychology, occupational therapy, pharmacy, and other allied health professionals who were available on a referral basis.

There was evidence of regular multidisciplinary meetings (MDT) with attendance from the full multidisciplinary team, depending on the needs of the individual patient. We were pleased to see that the MDT meetings notes were detailed and included updates from all professionals. The template also ensured that the actions and outcomes were also clearly recorded.

On the day of the visit, we discussed ongoing concerns in relation to individuals remaining in hospital when they were considered fit for discharge. There were three individuals in the service whose discharge was delayed. The multidisciplinary team meetings and chronological notes documented that delays were being actively addressed by the clinical team with health and social care partners.

The service also highlighted how they were addressing the issue. All individuals whose discharge was delayed were under regular review through the multidisciplinary team meeting. We were also told that on a fortnightly basis, the senior management clinical team, including service managers, commissioning services, the delayed discharge co-ordinator and the hospital flow co-ordinator met to review and expedite the process.

Use of mental health and incapacity legislation

On the day of the visit, six people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments.

There was one individual who had a certificate authorising treatment in place (T3) under the Mental Health Act. This was recorded appropriately with the correct documentation in place.

Where individuals were granted a Power of Attorney (POA) or where there was a guardianship order under the Adults with Incapacity (Scotland), 2000 Act (the AWI Act), a copy of the powers granted should be held on the care file, and the proxy decision maker consulted appropriately. We found paperwork for both the power of

attorney and welfare guardianship orders. The information was recorded and flagged as alerts in the individuals' electronic files. Throughout the chronological notes we also found evidence of contact with the proxy decision makers.

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. The certificate is required by law and provides evidence that treatment follows the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found section 47 certificates for all the individuals that we reviewed and where a proxy decision maker was appointed, they had been consulted.

Rights and restrictions

Cree Ward continues to operate a locked door, commensurate with the level of risks identified with the patient group. There was a locked door policy in place and available to all visitors entering the ward**.**

We reviewed individual restrictions on patients and were satisfied that restrictions imposed were commensurate with the risk assessments that were in place.

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

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.

Activity and occupation

The Commission recognises the importance of therapeutic and recreational activities, and we were pleased to hear from staff that this was something that they valued too.

On reviewing the chronological notes, we could see many individuals had regular input from a range of allied health professionals.

We heard about the service's plans for a joint project that will focus on maintenance cognitive stimulation therapy (MCST). This intervention supports wellbeing and mental stimulation through group activities, for people living with dementia. The service plan to run a four-week trial group and then review the process. We look forward to hearing about this on our next visit and finding out about its impact on an individual's care and treatment.

Additional support, assessment and treatment was provided by the occupational therapist, and we found functional assessments, preparation for discharge plans, and input that included recreational and therapeutic engagement.

We heard from the nursing team about their role in the delivery of activities. They ranged from social outings to arts and crafts and themed work linking with sports activities and holiday celebrations.

We understood that there are no ward-based activity co-ordinators, and by default, activities have become the responsibility of the ward staff. This can be difficult to prioritise when increased clinical needs have to be prioritised. We would urge managers to consider the value of having a dedicated activity co-ordinator in the ward to ensure that meaningful activity can be delivered routinely.

In the chronological notes we would have liked to have seen when activities were taking place, who had participated, and whether the activities had been beneficial to the individual's support, care, and treatment.

We recognise that an activity can be formal or recreational and can provide the opportunity for engagement between individuals and the ward-based team; we highlighted this to the ward-based team on the day of the visit.

Recommendation 1:
Managers should progress and consider the provision of an activity co-ordinator for the service.

Recommendation 2:
Managers should ensure that both nursing and occupational therapy staff document in the person's electronic file, the activities that the individual is offered and a summary of their engagement, and document if the individual refuses to participate.

The physical environment

Cree Ward offers a pleasant environment with individuals accommodated in single rooms, with en-suite facilities and access to a communal area that was well maintained.

There was access to an enclosed garden and the SCN informed us that there had been a recent application for funding and plans to build an outside gym and a sensory garden.

On the day we did note that the activity room and the high care sitting room was not being used due to damage to the roof, leading to water ingress, and damage to the internal ceiling and walls. We were informed that this matter was under review and there were plans for repairs to be completed.

Any other comments

We were given information on a quality assurance project that aims to embed into practice the stress and distress Newcastle formulation being conducted for all individuals which is in keeping with the Dementia standards, 2023.

The project looks to increase completion of the Newcastle formulations around activity being time bound, aligning this with the psychosocial model providing guidance on an individuals' life history, their diagnosis, having a trauma informed approach to care, medication, goals and interventions.

There is also a staff training component, ensuring that the proficiencies and skills are in place for building on the skills and knowledge base relating to the model. The staff training will also focus on raising carer awareness sessions, and on data collection regarding contact with the family.

We look forward to hearing about this project on our next visit to the service and hearing about the impact on the care and treatment that people receive.

Summary of recommendations

Recommendation 1:
Managers should progress and consider the provision of an activity co-ordinator for the service.

Recommendation 2:
Managers should ensure that both nursing and occupational therapy staff document in the person's electronic file, the activities that the individual is offered, and a summary of their engagement, and document if the individual refuses to participate.

Service response to recommendations.

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

Mental Welfare Commission 2024