

Mental Welfare Commission for Scotland

Report on announced visit to: Ward 4 A & B Larkfield Unit,
Inverclyde Royal Hospital, Larkfield Road, Greenock PA16 0XN

Date of visit: 9 April 2018

Where we visited

Ward 4 is located on the first floor of the Larkfield unit which is part of the District General Hospital. The unit has 20 beds for the assessment of older people and is designated as short stay. The ward is divided into two sub units; 4A provides 10 beds for people with dementia and 4B provides 10 beds for people with other mental illness. At the time of our visit there were seven patients in 4A and 10 in 4B. We last visited this service on 20 June 2016 and made recommendations relating to care planning, restrictions, provision of activities and catering.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at the use of the mental health and incapacity legislation.

Who we met with

We met with and/or reviewed the care and treatment of nine patients.

We spoke with members of the nursing team, the senior charge nurse, occupational therapist (OT) and consultant.

Commission visitors

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The ward has input from two consultant psychiatrists both of whom hold weekly multidisciplinary team (MDT) meetings. Occupational and physiotherapy staff attend the MDT along with medics and nursing staff. Social work attend case reviews when required. There is weekly pharmacy input, and out with this telephone advice is available. The ward has regular psychology input with a focus on management of stress and distress. The psychologist holds an open meeting weekly; staff can bring difficult cases or make referrals for assessment.

Other allied health professionals such as speech and language therapists and dieticians are available on referral and provide a responsive service. The ward also has access to the palliative care team when required.

MDT notes provide details of decisions made. There is evidence of patient and family involvement in decision making.

Initial assessments are thorough and include a risk assessment and assessment of physical healthcare needs. For patients with cognitive impairment there is life history

information recorded. Care plans addressed all identified needs including chronic health conditions. They are person centred, and reviewed and updated regularly.

Staff use the Newcastle model for management of stress and distress. We saw excellent detailed formulations which clearly identified triggers needs and management strategies in several patients' files.

Use of mental health and incapacity legislation

In relation to the Adults with Incapacity (Scotland) Act 2000 (AWI Act) we looked at a number of files which stated there was a power of attorney (POA) in place. Some files contained a copy of the powers or an indication that these had been requested from the proxy decision maker. However, we did find one file where the s47 alluded to a POA being in place, but there were no powers on file and no indication that action had been taken to verify this and obtain a copy of the powers.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. All patients who lacked capacity had an s47 in place with a treatment plan as appropriate.

Where patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003, copies of the detention paperwork was available as required.

Recommendation 1:

Managers should ensure care files are audited to include information relating to proxy decision makers being accurately recorded and a copy of the powers on file.

Rights and restrictions

The ward doors are locked and access is by a keypad code. There is a locked door policy and the code is provided within the key pad unit, but is not easily seen and there was nothing indicating how people can exit the ward. We had previously made a recommendation that this information should be provided. The senior charge nurse advised that the code had been put in place following our recommendation, but she was unclear what else was required. We discussed this further.

We had previously made a recommendation relating to the use of restraints such as reclining chairs and lap straps. At the time of this visit, there were no patients requiring this.

Recommendation 2:

Managers should ensure that information on how to exit the ward is available and clearly displayed.

Activity and occupation

During our previous visit we made a recommendation about activity provision which had been reduced as a result of vacancies within the OT department. We were pleased to see that the ward now has an OT assistant and noted that there was evidence of some activity provision within the notes. We look forward to seeing this provision continue to develop

The physical environment

On a previous visit we had commented on the lack of storage facilities and the impact this had on patient accessible areas, although we did not at that time make a recommendation. On this visit we found that the situation was unchanged. There were wheelchairs and large chairs stored in ward corridors. Areas used by patients, such as bathrooms and shower rooms, were being used to store hoists, commodes and other equipment. These are a potential hazard to patient safety, and make patient areas feel clinical and uninviting places to use.

Recommendation 3:

Managers should ensure that appropriate storage facilities are provided for wheelchairs, commodes, hoists etc. so that these are not cluttering up corridors, bathrooms and other patient areas.

Summary of recommendations

1. Managers should ensure care files are audited to include information relating to proxy decision makers being accurately recorded and a copy of the powers on file.
2. Managers should ensure that information on how to exit the ward is available and clearly displayed
3. Managers should ensure that appropriate storage facilities are provided for wheelchairs, commodes, hoists etc. so that these are not cluttering up corridors, bathrooms and other patient areas.

Good practice

We had previously made a recommendation in relation to care planning. On this visit we were pleased to find good quality care plans in place. Care planning was person centred, based on risk assessments, addressed all identified risk and needs and reviewed regularly in a meaningful way. All staff in the ward have been trained in the use of the Newcastle model for managing stress and distress. Where individuals were expressing stress and distress, we found very detailed formulations using the Newcastle model which identified triggers and needs, and provided clear strategies for addressing needs and managing distress.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland

Mike Diamond
Executive Director (Social Work)

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 MWC 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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