

Mental Welfare Commission for Scotland

Report on unannounced visit to: Knapdale Ward, Mid Argyll
Community Hospital, Blarbuie Road, Lochgilphead PA31 8JZ

Date of visit: 28 February 2018

Where we visited

Knapdale Ward is a 12-bedded dementia ward in Mid Argyll Hospital, which takes both male and female patients. We last visited this service on 10 May 2016, and we made no recommendations following this visit.

On the day of this visit, we wanted to look generally at how care and treatment was being provided in Knapdale Ward, because it was almost two years since our previous local visit.

Who we met with

On the day of this visit, there were seven patients in the ward, and we reviewed the case notes for all the patients. We were able to have brief conversations with several patients, but because of the advanced stage of their dementia, it was not possible to have meaningful discussions or to talk about their views on their care and treatment. On the visit, all of the patients seemed comfortable in their environment, and to be relating well to staff in the ward.

We spoke with the senior nurse on duty, with other members of the nursing team and with the service manager.

Commission visitors

Ian Cairns, Social Work Officer and visit coordinator

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

On our previous visit in May 2016, we saw that new care planning documentation had been introduced in the ward, and that there was evidence of good person-centred plans in the files we reviewed.

On this visit, we saw that care planning documentation continues to be well maintained. Individual care plans were clear and well recorded, with appropriate person-centred details about interventions and actions taken to meet identified care needs. There were detailed care plans relating to stressed and distressed behaviour, with triggers identified. In several files we saw copies of treatment escalation plans, with clear information about the ceilings of care and treatment relating to the individual patient. The plans we saw had good records of discussions with families about the ceilings of care, and about decisions which had been made about any treatments which would benefit the individual patient, or which would not benefit them, if their health deteriorated. There were comprehensive medical notes, with good assessment summaries. Files also had a sheet to record other discussions with family members and carers, so it was clear to see how relatives and carers participated in decisions

about care and treatment. In the documentation, we also saw a sheet which recorded key changes in a patient's needs, with a brief description of significant changes, and a record of when changes resulted in a review or in individual care plans being amended. We feel that the use of this documentation should help ensure that care plans are being evaluated and reviewed, with any required changes being made.

Use of mental health and incapacity legislation

Where patients were subject to measures under the Mental Health Act (Care and Treatment) (Scotland) Act 2003 (MHA), there was a helpful MHA index and review sheet.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the Adults with Incapacity (Scotland) Act 2000 (AWI), must be completed by a doctor. We saw s47 certificates in place in files on this visit.

Two patients were detained in the ward under the MHA. Treatment of these patients was authorised appropriately under the Act. We did see that one patient had been subject to compulsory measures, but was now receiving care and treatment in the ward as an informal patient. This patient was still prescribed 'as required' medication to be administered intramuscularly (IM) for agitation. Our view is that a patient is very unlikely to be consenting to IM medication for agitation, if this is felt to be urgently necessary, and this was discussed with the senior manager on the visit, who said they would take this issue up with the prescribing doctor.

Recommendation 1:

Managers should ensure that IM 'if required' psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances.

A number of patients in the ward had a welfare proxy appointed, either an attorney or a guardian. In one file we saw that a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form did not have a discussion with the welfare attorney recorded. In one file we also saw that a copy of the relevant order was not in place in the file. We did see that it was recorded in files that staff are asking for copies of a guardianship order or power of attorney, and we feel it is important that copies are provided and kept in the patient's personal file.

Recommendation 2:

Managers should ensure that staff follow up requests which have been made for copies of orders and that these are held within case files.

Recommendation 3:

Managers should audit DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion is recorded.

Activity and occupation

The occupational therapy service provides two to three sessions a week in the ward. There is an activity timetable in the ward, and ward staff try to organise some structured activities twice daily during the week, and once at weekends. Clinical duties will take priority, and we were told this could mean that ward staff are not able to arrange two activity sessions during weekdays.

The physical environment

The ward was clean and bright, with a garden which provides a safe and easily accessible area for patients and visitors.

Any other comments

There have been difficulties recruiting trained nursing staff to fill posts, and the ward is currently not accepting new admissions because of the reduced number of trained staff.

The Commission recognises that this is a national issue, and that nurse recruitment can be particularly problematic in rural areas. The Commission would have concerns about the impact on patients with dementia in community hospitals in Argyll and Bute who have been assessed as needing a period of assessment or care and treatment in a specialist mental health ward, if there can be no new admissions to the ward for a lengthy period of time. We would hope therefore that senior managers will be able to resolve issues about trained nursing staff posts in Knapdale Ward as soon as possible.

Summary of recommendations

1. Managers should ensure that IM 'if required' psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances.
2. Managers should ensure that staff follow up requests which have been made for copies of orders and that these are held within case files.
3. Managers should audit DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion is recorded.

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.

Alison Thomson
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 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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