



Mental Welfare Commission for Scotland

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

Date of visit: 7 February 2018

Where we visited

Muirton Ward is an older adult assessment unit for people with dementia. It has eight available beds. On the day of our visit there were eight patients on the ward. We last visited this service on 7 June 2016 and made recommendations in relation to discussion of the Adults with Incapacity (Scotland) Act 2000 (AWI), authorised treatments with welfare proxy and prescription audit to ensure compliance with legislation.

On the day of this visit, we wanted to follow up on the previous recommendations.

Who we met with

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

We spoke with the nurse in charge and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Ian Cairns, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

During our visit we saw staff interacting warmly with patients, responding quickly when they required assistance, and treating them in a respectful, caring manner. Staff had a good knowledge of the needs of the individuals in their care. Life history information was recorded in some files we reviewed, with 'Getting to know me' booklets, completed with help from relatives where co-operation could be obtained.

Care plans were written with regard to individual need of patients, and reviews took place regularly. The recovery plans followed on from risk assessment, management plans and detailed progress made. Multidisciplinary team (MDT) reviews were documented weekly, including those in attendance.

Where we saw 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in files, there was evidence of the involvement of guardians or attorneys in any advance decision not to give CPR.

Covert medication pathways were recorded following team discussion for those patients who were unable to consent and were non-concordant with medication administration.

Behavioural charts were completed, where appropriate, to help identify any triggers to stressed and distressed behavior. Additionally, staff held a debrief following any incident involving restraint, in order to determine the learning outcomes.

Use of mental health and incapacity legislation

Copies of powers of attorney, where these existed, were found in patient files. Adults with Incapacity Act, s47 certificates for the authorisation of treatment, had all been completed with appropriate treatment plans in place.

There were no issues with consent to treatment forms under the Mental Health (Care and Treatment) (Scotland) Act 2003. However, one informal patient had been prescribed intra-muscular (IM) medication 'if required' for agitation. As the patient was in hospital on a voluntary basis and should be giving consent to the administration of medication, we did not agree that this prescription was appropriate.

There were other oral 'as required' medications prescribed in variable doses and we felt that having a fixed dosage and daily maximum would make the prescription less vulnerable to confusion or medication error.

Recommendation 1:

Managers should ensure that patients not subject to compulsory treatment should not be prescribed IM medication 'as required', especially where they lack capacity to consent.

Recommendation 2:

Managers should review the prescription of 'as required' medication as fixed rather than variable doses.

Rights and restrictions

As the individuals in the ward all had a diagnosis of dementia, the external fire door to the ward was locked to maintain safety and to prevent patients leaving the ward unnoticed. All staff had a key should the door need to be unlocked in an emergency. Although the door to the ward was locked, this was not causing any undue concerns to patients and the locked door policy was on display.

Bed rail assessments were clearly documented and, where these were not appropriate, falls mats were occasionally used to alert staff of patients at risk of falling whilst attempting to get out of bed at night unaided.

Activity and occupation

There was a weekly timetable of activities, which was mostly delivered by nursing staff when they were not engaged in meeting other clinical needs for patients. In addition, the ward engaged an art therapist one day per week and the artwork produced was on display throughout the ward. Efforts were being made to encourage patients to participate in activities but, when this was declined, it was generally not recorded. Understanding when and why this happens may enable staff to determine how participation can be improved in future.

We also saw very good examples of individual patients, who now have difficulty participating in group activities, being encouraged to participate in one-to-one activities designed around interests identified from the person's life history.

Recommendation 3:

Managers should ensure that participation in activities is documented, including where these have been offered and declined.

The physical environment

The ward was spacious with plenty of options for patients to mix with others, or to spend time in a quiet area. There was a combination of dormitory and single room bed areas allowing for a degree of flexibility according to needs and wishes. There was dementia friendly signage helping individuals to find their way around. There was also a large conservatory and dementia friendly garden. The atmosphere was calm and relaxed on the day with good interaction observed between staff and patients. The flooring was the main negative feature, with an interlocking block design giving the impression of steps, potentially confusing for anyone with poor eyesight or cognitive impairment.

Recommendation 4:

Managers should consider replacing the flooring with more uniform and matt vinyl in keeping with dementia friendly design standards.

Any other comments

It was good to see lots of information displayed on notice boards both for patients and visitors, including a copy of the previous Mental Welfare Commission visit report.

Summary of recommendations

1. Managers should ensure that patients not subject to compulsory treatment should not be prescribed IM medication 'as required', especially where they lack capacity to consent.
2. Managers should review the prescription of 'as required' medication as fixed rather than variable doses.
3. Managers should ensure that participation in activities is documented, including where these have been offered and declined.
4. Managers should consider replacing the flooring with more uniform and matt vinyl in keeping with dementia friendly design standards.

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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