

Mental Welfare Commission for Scotland

Report on announced visit to: The Prosen Unit, Whitehills Health and Community Care Centre, Station Road, Forfar DD8 3BY

Date of visit: 16 April 2018

Where we visited

Prosen Unit in Whitehills Health and Community Care Centre is a mixed-sex ward with 10 beds, providing admission, assessment, and treatment for people with dementia. The ward is based in a community hospital, and has 10 single en-suite rooms. We last visited this service on 20 December 2012.

On the day of this visit, we wanted to look generally at the care and treatment being provided, because the unit had not been visited for a number of years.

Who we met with

We met with and/or reviewed the care and treatment of seven patients. We also met four relatives during the visit.

We spoke with the general manager, the ward manager, and other members of nursing staff. We also spoke with the trainee doctor providing medical input in the ward.

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

We were only able to have a meaningful conversation with two patients, both of whom seemed settled in the unit's environment, and raised no issues about their care and treatment. We also met four relatives, who were all positive about the care provided in the unit. We heard a number of comments from relatives about how staff in the unit were helpful and supportive, that staff provide good information and keep relatives up to date appropriately about how treatment is progressing and future plans. One relative in particular told us that they visit regularly and at different times during the day, they always feel welcome in the ward, and they can see that staff know the patients well, and treat them with a great deal of patience and respect.

The files we reviewed were well organised and maintained, with information easy to locate in each individual patient file. Care plans were person centred, with good details of nursing actions and interventions. Care plans are evaluated regularly, at least on a monthly basis, and it was helpful to see evaluations recorded in a sheet behind each individual care plan. We were also pleased to see recovery care plans in place, as a recovery focus is often not common practice in dementia units. Multidisciplinary team (MDT) meetings are well recorded, with clear information about decisions made at meetings, and actions to be progressed.

We saw 'Getting to Know Me' forms in individual files, with a lot of information recorded in each document, giving staff in the unit good information about each individual patient, their life history and their needs, interests and preferences. One relative specifically told us that they felt the staff in the ward place a lot of importance on getting to know their patients and understanding them, and this seems to be reflected in the information collected in the 'Getting to Know Me' document.

We saw on reviewing the files that good attention is paid to meeting physical healthcare needs. This was confirmed when we spoke to the doctor in a training post who is on a rotation in the ward. They described their role and the input from general practitioners from one of the local practices, who come into the ward twice weekly. We also saw evidence of good input from other health professionals, for example with input from dieticians when this was appropriate. Discussing this with staff on the ward, we heard that because Whitehills is a community hospital other health professionals working in the community are based there, and Prosen Unit has very good access to these professionals.

Some care plans referred to individual patients having one-to-one time with nurses, in relation to specific needs. This input is recorded in the daily continuation notes, but we did note that these contacts were not highlighted specifically as one-to-one contacts. It was clear from discussion with staff nurses that planned one-to-one contacts are taking place, and we think it may be helpful to highlight this in the continuation notes, to assist with the process of monitoring and evaluating care plan actions.

Use of mental health and incapacity legislation

Several patients were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the mental health act). Where people were subject to compulsory measures under the mental health act, medication administered was authorised appropriately by T3 certificates. The certificates completed by a designated medical practitioner authorises treatment. Copies of the T3 forms were in patient files where appropriate but were not filed with the medication sheets. We would suggest that it is good practice to keep a copy of the T3 forms in the folder with the drug prescription sheets.

A number of patients in the unit had previously granted powers of attorney. This was well recorded in files, with copies of powers also seen in files. One relative who has been granted powers of attorney also told us that they felt staff involved them fully in any discussions about treatment, and in any decisions about treatment which were being made. They felt that they were given good information about any changes to the care and treatment which were being considered, and that the authority they had to consent to treatment was clearly recognised and respected. Where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place in files, we also saw that consultation with the attorney or guardian was recorded. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under

s47 of the Adults with Incapacity Act should be completed by a doctor. We saw s47 certificates in place where appropriate.

Recommendation 1:

Managers should ensure that copies of T2 or T3 forms are kept with the drug prescription sheets.

Rights and restrictions

From the files reviewed in the Prosen Unit it was clear that compulsory measures under the mental health act are put in place when this is felt to be appropriate and necessary.

The doors to the unit were locked on the day of our visit, but information about a locked door policy was clearly displayed as you entered the ward. The use of covert medication pathways was noted in some of the files we reviewed, and it is clear that decisions about the administration of covert medication are reviewed regularly, and are discussed at MDT meetings.

Activity and occupation

An occupational therapy assistant provides input into the ward for three sessions a week. This can involve working with individual patients, and also facilitating group activities. The nursing team in the ward will also engage patients in activities.

The ward is based in a community hospital and staff feel that this has positive benefits, as it encourages community engagement within the ward. A number of volunteers come into the ward regularly to provide activities, and a music session was taking place on the day of our visit, arranged by a volunteer. Volunteers help with maintaining the garden in the ward, and encouraging patients to use the garden. There is also input from senior pupils from the local secondary school in the ward. Input from volunteers seems to be actively encouraged, and patients are also assisted by staff or by families to use local facilities, such as the dementia café in the town.

The physical environment

The ward is a 10-bed ward, and all rooms are single en-suite rooms. The number of beds in the unit has been reduced since it first opened, and the space is being used creatively to provide more communal areas, where activities can take place. There is also easy access to a sheltered, secure and well maintained garden from the ward.

Any other comments

As mentioned in the activity section above staff feel that there are particular benefits from the unit being based in a local community hospital. This certainly seems to encourage input from the community, to enable patients to access local facilities

whenever possible, and also to ensure that there are strong links with other health professionals who are based in the community hospital.

Summary of recommendations

1. Managers should ensure that copies of T2 or T3 forms are kept with the drug prescription sheets.

Service response to recommendations

The Commission requires a response to this recommendation 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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