Mental Welfare Commission for Scotland

Report on announced visit to: Glen O'Dee Hospital, Scolty Ward, Corsee Road, Banchory AB31 5SA

Date of visit: 24 May 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was able to be carried out face-to-face.

Scolty Ward is an older adult assessment unit for people with dementia, co-located on the same site as the community hospital. The ward has 12 beds and on the day of our visit there were 10 patients on the ward. Of the 10 patients on the ward, five had been admitted from care home settings. We last visited this service on 25 February 2020 and made recommendations about care plans, the environment and section 47 treatment plans.

On the day of this visit we wanted to follow up on the previous recommendations and speak with patients, relatives and staff.

Who we met with

On the day of the visit we spoke with the senior charge nurse (SCN) and ward staff. We spoke with and reviewed the care and treatment of five patients and spoke with two relatives.

Commission visitors

Tracey Ferguson, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

Throughout the day of our visit, we chatted to most patients in the ward, however we were not able to have detailed conversations with all patients, because of the progression of their illness. Where we were able to have a more in-depth discussion, a few patients told us that they were happy with the ward staff and were able to give an explanation of the reason for admission. We observed that most patients appeared settled and content in the ward environment and, where patients were displaying distressed behaviour, we saw staff attend to this.

The ward has recently been closed due to an outbreak of Covid-19, and relatives told us that staff kept in regular contact during this time, however were pleased when the ward opened again for visiting. Relatives told us that the staff appeared caring.

Managers told us about the ongoing staffing challenges in trying to fill staff vacancies and recognised recruitment of nurses is a national issue and it can be more difficult to recruit in rural areas. We were told about the continued proactive efforts to recruit staff and how the ward currently uses regular bank nurses, to ensure continuity and safe delivery of patient care.

Nursing care plans

Of the patient files we reviewed, most had a detailed nursing assessment which was completed on admission, along with a risk assessment and risk management plan. However in some files, we found a lack of detail in the nursing record when the patient was admitted.

We saw evidence of physical health care monitoring on admission and throughout the patient's journey. Where covert medication pathways were in place we saw appropriate documentation. Some files had completed 'Getting to know me' booklets, with help from relatives and these provided information about the patient's background.

Where do not attempt cardiopulmonary resuscitation (DNACPR) forms were in place, we were pleased to see that discussions with the proxy/relative had been recorded.

We wanted to follow up on our last recommendation regarding care plans. On our last visit we found that some initial assessment care plans were still in place several weeks after admission and this was also raised on our previous visit in 2018. We wanted to know what progress had been made in regards to care plan reviews and evaluations, to ensure they remained meaningful throughout the patients' journey.

Unfortunately we found that many of the care plans had been completed on admission and had not been updated since. Following the assessment period, we would expect to see a comprehensive individualised care plan that details interventions to support the patient to meet their identified goals. As these were not consistently being done, many of the reviews and evaluations did not correspond with the care plans and it was difficult to know the outcome of the assessment, as care plans had not been updated. The standard of daily nursing note entries was variable, with some lacking detail and evidence of interaction between patients and staff. This sometimes made it difficult to see if patients were making progress throughout their admission.

We were made aware of one patient whose discharge had failed in less than 24 hours of being discharged from the ward. There was no recorded entry from nursing staff about this patient's views on going to a care home. Where a patient has capacity, or is assessed as lacking capacity, gaining their past and present views is a crucial part of the assessment process. This was lacking, as was evidence that the principles of the Adults with Incapacity (Scotland) Act 2000 (AWIA) were being incorporated into practice. We also followed up on a case where we had concerns about a patient who was transferred to a care home in hospital scrubs. It had been recorded in the nursing notes that the patient had no clean clothes. We were concerned about the failure to protect this patient's dignity and also the discharge planning process.

The ward is a dementia assessment unit, therefore we wanted to find out how staff were supporting patients presenting with stress/distress behaviours. We were told that five of the patients had been admitted from care home placements due to their significant level of stress/distress behaviours. We were told that all staff have undergone stress/distress training and the ward has two appointed ambassadors, including the SCN.

It was positive that each patient had a quick guide to manage stress/distress behaviours in their notes, however given that all staff are trained in this specific area, we expected the care plans to be very person-centred, containing detailed interventions to support the patient with their stress/distress. We found a lack of detail in the stress/distress care plans, and a lack of supporting documentation. Many care plans recorded the use of non-medical strategies to support patients, but these were not specified in the care plan. Interventions such as 'use distraction techniques' were mentioned to support the patient, but there were no descriptions of what these actually were, nor identifying the triggers that were causing the patients distress. Therefore we found that some patients were given psychotropic medication to reduce symptoms of stress and distress behaviours, rather than utilising non-medical interventions.

There appeared to be little improvement in terms of our previous recommendation regarding care planning, so we wanted to find out what action was being taken by managers. The SCN told us that there was a monthly audit programme in place, however from discussion it would seem that the audit did not focus on the qualitative information in patient files.

We were significantly concerned about the language used by nursing and ward staff in the patient notes. The choice of language did not support the stress/distress model of care being delivered to this patient group. The language used to describe patients was at times negative, pejorative and not patient centred, giving the impression that staff lacked in understanding of dementia-related illnesses.

Given that there is an auditing programme in place, it was concerning to see the negative language used by staff had not been identified and addressed during the monthly audits. We raised our concerns with senior managers on the day, as we felt this situation required to be urgently addressed. We shall follow up with senior managers to ensure appropriate action has been taken.

Recommendation 1:
Managers should review their audit processes to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 2:
Managers should ensure that all nursing documentation and practice complies with the Nursing and Midwifery Council Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Patients care plans had not been signed, although some recorded that they were unable to be signed due to lack of capacity. There appeared to be lack of involvement where the patient had an appointed proxy decision maker under the AWIA. We discussed this further with the SCN and felt that it would be good practice to either share the care plans or record that there has been a discussion with the proxy on the documentation.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)

Two consultant psychiatrists cover the ward and we were told that multidisciplinary (MDT) meetings continue to take place weekly. We were told that the attendance at the meetings mainly consists of the consultant psychiatrist, nursing staff and mental health occupational therapy (OT) staff. The level of detail recorded in the MDT minutes was variable. We found a lack of detail in regards to discharge planning. We were told that there are three patients who have been assessed as being medically fit for discharge, however their discharges were delayed. We wanted to find out more about discharge planning and if there were pre-planned discharge meetings held with all professionals involved, including relatives and social work. Relatives we spoke to told us that they did not always feel involved, as many decisions had been made at the MDT meeting, which they were not part of. We were told that a nurse updates the social worker via email after the meeting.

The SCN told us that discharge meetings have not taken place with the wider MDT, including relatives, since the Covid-19 pandemic, however they were looking to recommence these. From reading patient files we found that some decisions were being made on admission, before assessment had even concluded. We found a patient had been recorded as being medically fit for discharge but was still receiving regular “as required” medication on a daily basis. This was concerning as no assessment had been undertaken and it appeared that the patient’s level of stress/distress was more than would be expected if a patient was ready for discharge.

Recommendation 3:
Managers should ensure that the MDT records clearly record all actions and that the views of the patient, their relatives and/or proxy are sought and included.

Recommendation 4:

Managers should ensure that where a patient is assessed as being medically fit for discharge, discharge meetings are arranged with all professionals and carers / relatives invited.

The ward continues to have access to allied health professional (AHP's) via a referral system. The ward does not have any dedicated psychology support. We were told that patients can also access physiotherapy quickly as this service is based on the same site as the ward.

Use of mental health and incapacity legislation

No patients were subject to detention under Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) on the day of our visit.

For patients who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 (AWIA), we saw copies of the legal order in all but two of the patient files. We brought this to the SCN's attention on the day. There were some entries that recorded the patient was subject to AWIA, rather than the specific legal order. We brought this to the SCN's attention, as this lack of clarity regarding the measures authorised under AWIA legislation could lead to confusion. Where a person has an appointed power of attorney (POA) in place, it was not always clear whether or not the patient was deemed to have capacity. This should be recorded so that staff are clear and can record if the POA has been activated.

We wanted to follow up on our previous recommendation regarding section 47 certificates and treatment plans. Where patients are assessed as lacking capacity to consent to treatment and they are being provided with treatment under Part 5 of the AWIA, section 47 certificates that authorise treatment should be completed. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. A section 47 certificate provides authority only for medical treatment under part 5 of the AWIA and does not provide legal authority regarding welfare matters.

We saw that all patients had a section 47 certificate completed, however the completed treatment plans were variable and were not all completed in accordance with AWIA code of practice for medical practitioners. Many of the certificates and treatment plans did not record if the doctor had consulted with the proxy/guardian. We were disappointed to see that no improvement had been made since our last visit. This matter will be escalated to senior managers in NHS Grampian and the HSCP.

Administration of "as required" intra muscular (IM) psychotropic medication almost always requires the legislative authority of the MHA. The Commission is concerned when IM 'as required' medication is being prescribed for informal patients. This is because it is unlikely that there would be consent to receive this treatment if it had to be administered in circumstances where restraint may be required. We consider it best practice for a medical review to be arranged if there are exceptional circumstances where IM medication may be required. We found that one patient had been prescribed and had been administered medication in this way, however this had now been discontinued. The Commission is continuing to follow up on this matter with another service area and agreed with NHS Grampian that the managers of Scolty ward will be included as part of any follow up discussion/advice.

Recommendation 5:
Managers should ensure intramuscular "as required" psychotropic medication is not prescribed for informal patients other than in exceptional individual circumstances

Rights and restrictions

The door to the ward is locked and there is a notice to explain this. We are aware that Aberdeenshire north east advocacy service provides advocacy support to patients on the ward, however on the day of our visit we were unsure if any patients had support, as there was no evidence in the patients' files.

We were aware that some of the patients on the ward have no POA/guardian or relatives involved. None of the patients were detained under MHA, so it was difficult to determine the safeguards that were in place in terms of restrictions and ensuring their rights were being upheld. We discussed this further with the SCN.

Recommendation 6:
Managers should ensure that all patients have access to independent advocacy and that advocacy referrals are discussed in the MDT and recorded.

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. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

On the day of the visit we wanted to find out about activities for patients. We found little evidence in the patient notes of activities, which was disappointing, particularly as activities can support patients in managing stress/distress behaviours, often resulting in the decrease in medication to manage such behaviours.

The SCN told us that she has recently appointed an activity therapist who is specifically dedicated to provide patient activities. We look forward to hearing about this new development, along with the evidence of how therapeutic activities are helping patients who may have stress/distress behaviour.

The physical environment

The ward has single rooms and shared dormitories, along with a large dining / sitting area. There is a long corridor that goes off to the patient's rooms, where we saw patients walking up and down the corridor throughout the day. Some single rooms lead to a conservatory area that provides families with a quiet area, when their relative is receiving palliative care. We felt this space was really supportive for families, and allowed them the privacy at a difficult time.
The ward has developed an indoor garden area which was bright and has access to the outdoor garden. However, we were told that the outdoor garden area cannot be used at present as parts are in disrepair. Outdoor space can be beneficial in improving patient wellbeing, but also managing patient's stress/distress. We consider that it is important for patients to have access to a safe outdoor space.

We wanted an update on the environment following on from our last visit. We were told that some of the flooring has been replaced however there were other areas that were hazardous for patients, and needed repaired. There was a leak in the ceiling in one of the dormitories and we were told that this had been reported.

The ward continues to have one shower room and one bathroom for all patients. We were aware that the shower room continues to cause difficulties for patients who require support with their personal care, due to the size of the room. We wanted to find out what action managers have taken in relation to the repairs and outstanding works in the ward, therefore we will follow this up with them.

Recommendation 7:
Managers should ensure that the garden area is made safe for patients to access and any repairs outstanding should be attended to as a matter of priority.

Any other comments

This visit has highlighted areas of concern which senior managers require to address with the SCN, ward staff and clinicians. The purpose of the ward is to provide assessment for older adults with dementia, therefore staff require to have the appropriate knowledge and skills to provide this specialist input to patients admitted to the ward. Senior managers need to ensure that the culture and ethos of the ward is meeting this need and that the staff team receive the necessary support, training and leadership to effect this change.

Summary of recommendations

1. Managers should review their audit processes to improve the quality of care plans and ensure that evaluations of care plans clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

2. Managers should ensure that all nursing documentation and practice complies with the Nursing and Midwifery Council Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

3. Managers should ensure that the MDT records clearly record all actions and that the views of the patient, their relatives and / or proxy are sought and included.

4. Managers should ensure that where a patient is assessed as being medically fit for discharge, discharge meetings are arranged with all professionals and carers / relatives invited.

5. Managers should ensure Intramuscular "as required" psychotropic medication is not prescribed for informal patients other than in exceptional individual circumstances.

6. Managers should ensure that all patients have access to independent advocacy and that advocacy referrals are discussed within the MDT and recorded.

7. Managers should ensure that the garden area is made safe for patients to access and any repairs outstanding should be attended to as a matter of priority.

Service response to recommendations

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

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.

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