Mental Welfare Commission for Scotland

Report on announced visit to:

Inverclyde Royal Hospital, Wards 4 A & B, Larkfield Unit, Larkfield Road, Greenock, PA16 0XN

Date of visit: 7 July 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and for a time we were undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

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 illnesses. At the time of our visit there were five patients in 4A and ten in 4B, two of which were adult patients, boarded into the ward. We were advised this was not a regular occurrence and was due to a Covid-19 outbreak in the adult admission unit.

We last visited this service on 24 August 2021 and made recommendations in relation to the recording of life history information and 'Getting to know me' documentation, care planning for stress and distress, mental health and activity. We also made recommendations relating to treatment under the Adults with Incapacity (Scotland) Act 2000 (AWI Act).

The response we received from the service was that our guidance on care planning had been circulated to staff, training was being provided in relation to management of stress and distress and there was an ongoing audit programme and line management supervision in place, providing monitoring and quality assurance.

On the day of this visit we wanted to follow up on the previous recommendations and also look at how the service is responding to the relaxation of Covid-19 restrictions.

Who we met with

We met with and reviewed the care and treatment of seven patients. No relatives or carers asked to meet with us.

We spoke with the senior charge nurse, staff nurse and patient service manager.

Commission visitors

Mary Hattie, nursing officer

Margo Fyfe, senior manager, (practitioners)

What people told us and what we found

Care, treatment, support and participation

The ward has input from a locum psychiatrist who covers the catchment area. There is also regular input from psychology, occupational therapy, physiotherapy and pharmacy. Input from other professionals, including dietetics and speech and language therapy, can be arranged on a referral basis. Social workers are involved on a case-by-case basis. The ward has a number of registered nurse vacancies and is using bank and agency staff to maintain staffing levels while these posts are recruited to.

Chronological notes are recorded on EMIS, the electronic record keeping system. Multi-disciplinary (MDT) meetings should also be recorded here, however, whilst we found that there were brief entries of ward rounds in the files we reviewed, we could not find minutes of MDT reviews containing information on who attended and what decisions were made.

We were pleased to see that the majority of patients whose care we reviewed did have a completed 'Getting to know me' on file, however the level of information these contained varied considerably, with some containing very little detail about the individual's previous life. This is a document which records a person's needs, likes and dislikes, personal preferences and background, aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. We had previously recommended that 'Getting to know me' be completed and life history information recorded in patient's files. As most patients will move on to further care placements it is important that this information is recorded and goes with them through their care journey. Unfortunately we could not find any evidence of life history information being collated and recorded in the files we reviewed.

We reviewed the files of a number of patients who were prescribed as required medication for agitation, or were on enhanced levels of observation; however there were no care plans for the management of their stress and distress. It is essential that, where an individual suffers from stress and distress, a care plan is developed that identifies the potential triggers for the individual and identifies how this may be managed to ensure the safety and wellbeing of both patients and staff. This was also a previous recommendation.

Whilst risk assessments were reviewed regularly and we found regular care plan reviews documented, the care plan reviews lacked meaningful detail and were not updated to reflect changes in individuals' presentation and needs. The care plans were not person centred; lacking information about the needs, treatment goals and interventions for the individual patient. As we had made recommendations in relation to care plans on our previous visit we were disappointed to find that no progress had been made in relation to this issue. We discussed the importance of getting this documentation correct to reflect the individuals care. We agreed that there would be benefit in asking the practice development nurse for the area to assist in making improvements.

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

Recommendation 1:
Managers should audit MDT notes to ensure these are clearly identified as such on EMIS and contain a record of those present, detail of the decisions taken and a clear action plan.

Recommendation 2:
Managers should put in place the necessary support and audit processes to ensure that 'Getting to know me' documentation is fully completed and that life history information is recorded and follows the patient when they move to a further care placement.

Recommendation 3:
Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.

Recommendation 4:
Managers should review their audit processes to improve the quality of care plans to ensure these are person centred and updated to accurately reflect the patient's current needs and planned interventions.

Recommendation 5:
Managers should, as a priority, provide line management and have the practice development nurse support the ward to ensure that the above recommendations are implemented.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA), copies of detention paperwork were on file.

Part 16 (s235-248) of the MHA sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Where required, certificates authorising treatment under the MHA were in place and covered all prescribed treatment.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), this was recorded. However not all of the files we reviewed contained copies of the powers held by the proxy and it was unclear from the file whether these had been requested.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found completed section 47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity; consultation with proxy decision makers had been recorded.

Recommendation 6:
Managers should ensure that where a power of attorney or guardianship is in place, copies of the powers granted are held on file.

Rights and restrictions

The ward doors are secured by a keypad entry system. Visitors exit and enter with the assistance of nursing staff. There is information about this on display.

Visiting has returned to pre-pandemic arrangements, in line with government guidance; visits no longer need to be booked in advance. Visiting times are in the afternoon and in the evening however visits out with these times can be arranged if requested.

The ward has access to advocacy, and details of the service are on display on the notice board.

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

The ward has input from an occupational therapist, an occupational therapy assistant and a patient activity co-ordinator who provide a range of therapeutic and recreational activities on a one-to-one and group basis. The patient activity co-ordinator role is a recent development, and this post provides input across two wards. Nursing staff engage in informal activities on an individual and small group basis. The ward also has input from a physiotherapist who provides an exercise class and patients who wish it can use the gym in the Argyll unit. There is an activity board in each ward giving information on the activities planned for the week. We saw patients participating in a range of activities during or visit.

Access to a range of face to face external supports such as therapet and music therapy have not yet recommenced, however patients are supported to go on outings into the community, either with staff or with their visitors and to use the facilities in the Argyle unit that includes a therapeutic kitchen; this is used for assessments and small group cookery activities.

In the chronological notes we found meaningful information on activity participation and preferences recorded by the patient activity co-ordinator and occupational therapist, however whilst we found activity care plans in most of the files we reviewed, these were not person centred and had not been updated to include information on the individuals previous hobbies or activity preferences.

Recommendation 7:
Activity care plans should be reviewed to include person centred information about the individuals' hobbies, skills and interests.

The physical environment

The ward is on the first floor of the Larkfield unit, but patients do have access to a pleasant secure garden area. Beds are provided in a mixture of single en-suite rooms and small dormitories. In 4A, the dementia unit, there is one large communal sitting, dining, and activity area. This can become noisy at times, which can be distressing for some patients. The dining and sitting areas in 4B are separate. There is dementia friendly signage throughout the unit. The ward is clean and bright, however the décor is rather drab and clinical and there is no evidence of personalisation around bed spaces. We were told that redecoration, which was being scheduled when we last visited, has been delayed due to Covid-19 restrictions, but will be rescheduled in the near future. We look forward to seeing this on our next visit.

Summary of recommendations

1. Managers should audit MDT notes to ensure these are clearly identified as such on EMIS and contain a record of those present, detail of the decisions taken and a clear action plan.

2. Managers should put in place the necessary support and audit processes to ensure that 'Getting to know me' documentation is fully completed and that life history information is recorded and follows the patient when they move to a further care placement.

3. Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.

4. Managers should review their audit processes to improve the quality of care plans to ensure these are person centred and updated to accurately reflect the patient's current needs and planned interventions.

5. Managers should, as a priority, provide line management and have the practice development nurse support the ward to ensure that the above recommendations are implemented.

6. Managers should ensure that where a power of attorney or guardianship is in place, copies of the powers granted are held on file.

7. Activity care plans should be reviewed to include person centred information about the individuals' hobbies, skills and interests.

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.

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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