Mental Welfare Commission for Scotland

Report on announced visit to: Maple Villa, Larch Grove, Livingston EH54 5BU

Date of visit: 31 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 carried out face-to-face.

Maple Villa is a 24-bedded unit which provides care and treatment for older adult males with dementia who are experiencing stress and distress. Due to refurbishment works in the ward, on the day of our visit, the bed capacity was reduced to 16 single rooms. There were three available beds.

The ward has a multidisciplinary team (MDT) consisting of nursing staff, consultant psychiatrist, general practitioners (GP), occupational therapist (OT) and a pharmacist. There is also input available from psychology and referrals can be made to all other services as and when required.

We last visited this service on 5 December 2019 and made recommendations regarding care planning, compliance with part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) and part 5 of the Adults with Incapacity (Scotland) Act 2000 (AWIA) and an environmental audit.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how patients and staff have managed throughout the current pandemic.

Who we met with

We met and reviewed the care and treatment of four patients and spoke with one relative.

Prior to the visit we met with the clinical nurse manager and senior charge nurse (SCN) via video call and spoke with other clinical staff on the day of the visit.

Commission visitors

Gillian Gibson, nursing officer

Tracey Ferguson, social work officer

What people told us and what we found

Care, treatment, support and participation

Due to the progression of their illness, we were unable to have detailed conversations with patients, however, throughout the day we introduced ourselves to a number of patients and observed them to be content and relaxed in the ward. We observed supportive and positive interactions between ward staff and patients during our visit and it was evident from these observations and discussions with staff that they were knowledgeable and enthusiastic regarding their patients and the care and input that they provide.

Feedback from relatives was generally positive. They felt nursing staff were approachable and were kept up to date with information regarding care and treatment. There was some confusion regarding what to expect on admission and general processes in the ward. We were pleased to hear that the information leaflet for patients, carers and relatives was being updated and the SCN had recently invited relatives to book individual meetings with them should they wish this opportunity.

Visiting arrangements continue to be supported. We heard how the Covid-19 pandemic had affected visiting and how difficult this had been for relatives. At the time of our visit, arrangements were made via a booking system but we were pleased to hear that the ward has adopted a person centred, flexible approach to visiting where this has been required, particularly if someone was receiving end-of-life care.

Nursing care plans

We found examples of person-centred care planning covering a range of mental health and physical wellbeing areas with detailed information and summative reviews, however, it was recognised that the electronic patient information system in use does not support mental health care planning, specifically in relation to stress and distress. We were informed that this has been highlighted to the management team. We saw that physical health care needs were being addressed and followed up appropriately.

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)

The ward has a range of disciplines either based there or accessible to them. GPs attend the ward five days per week to support physical health and wellbeing. We were concerned about the lack of consultant psychiatry input to the ward with the current arrangement in place being one visit per fortnight. We were pleased to hear that efforts had been made to recommence family involvement and participation by holding a review meeting for two patients each fortnight. However, this arrangement meant that individual patient reviews were not taking place on a regular basis. We did not find this arrangement adequate in relation to the complex care needs of the patient group. OT and pharmacy input is also currently one session per week

and they do not coincide with MDT meetings. As a result, these meetings are only attended by medical and nursing staff.

There is an MDT meeting template which is used to provide a record of clinical discussion and outcomes. We were concerned that this is completed by nursing staff only, on paper format and we could not find detailed documentation in any of the care records from the consultant psychiatrist.

Recommendation 1:

Managers should review the level of consultant psychiatrist input to the ward to ensure all patients are reviewed on a regular basis.

Recommendation 2:

Managers should ensure there are comprehensive detailed records entered on the electronic patient management systems by all medical staff.

Recommendation 3:

Managers should ensure all disciplines are represented at or have the opportunity to provide input to MDT meetings.

Care records

The ward had recently introduced the electronic system, Trakcare to hold information on patient's care and treatment. We found this system relatively easy to navigate although recognised this system was not designed for mental health. We were able to see where specific pieces of information were located on the system including mental health legislation. We found that overall there was a good standard of record keeping with daily notes linked to care plans, however, we would expect to see evidence of non-pharmacological interventions used and the effectiveness of these documented prior to the administration of as-required medication for stress and distress.

All staff involved in the patients care should be able to input into the electronic system with the aim of promoting the continuity of care, communication and information sharing. We were unable to find entries from the GPs and heard that they do not use this system. As a result, nursing staff are required to complete an entry detailing care and treatment recommendations following visits. We were concerned that second hand information could pose a risk of inaccuracy and missed information.

Recommendation 4.

Managers should give consideration to developing a robust process to ensure information from GP consultations are able to be directly added into the Trakcare record.

Use of mental health and incapacity legislation

On the day of our visit, three patients were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients,

who are either capable or incapable of consenting to specific treatments. On our previous visit we made a recommendation in relation to compliance with part 16. Of those patients subject to compulsory treatment, we reviewed the legal documentation available in their files. We were pleased to find that paperwork relating to treatment under part 16 of the Mental Health Act was in order. The authorising treatment forms (T3s) completed by the responsible medical officer to record non-consent were available and up to date.

We also made a recommendation regarding part 5 of the Adults with Incapacity (Scotland) Act 200 (AWIA) section 47. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWIA must be completed by a doctor. The certificate is required by law and provides evidence that the treatment complies with the principles of the Act. Consent to treatment certificates were in order along with accompanying care and treatment plans, however, treatment plans did not detail specific treatment covered by the certificate. Many treatment plans also contained irrelevant information pertaining to diagnosis, day to day presentation and compulsory treatment. We would also expect these to have been discussed and agreed with relatives/carers.

There did not appear to be a clear process to identify where there was a welfare proxy (guardian or power of attorney) in place and ensuring details were recorded and copies of powers kept in individual files. Uncertainty regarding legal powers in place can lead to decisions being made without proxy involvement.

For those patients on covert medication pathways, all documentation was in place and reviewed regularly however a number of these did not evidence relative/carer/proxy involvement which we would expect to see.

Recommendation 5:

Managers should ensure medical staff refresh their knowledge of the Adults with Incapacity (Scotland) 2000 Act code of practice 3rd edition to ensure compliance with part 5 of the act and an audit of certificates and treatment plans is undertaken on a regular basis.

Recommendation 6:

Managers should ensure there is a clear process to identify when there is a welfare proxy in place and ensure this is documented clearly and accurately.

Recommendation 7:

Managers should ensure processes are in place to support relative/carer/proxy involvement in care decisions and this evidence clearly documented.

Rights and restrictions

Maple Villa continues to operate a locked door, due to the level of risk identified in the patient group. This was clearly displayed in the ward on the day of our visit. We also saw evidence of individual risk assessments that identified patients who would be at risk if the door were to be open due to their vulnerability and progression of their illness.

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

Maple Villa has an activity co-ordinator who works Monday to Friday 9am-5pm. Unfortunately, they have been absent for a considerable time prior to our visit. We were pleased to hear that a member of nursing staff had been appointed to co-ordinate activities and saw evidence of an activity programme in place which incorporated themed days of activity. The ward also had an activity room with a variety of equipment for patients to use.

The ward has input from an OT who provides assessment for focused activities. We saw that work had been undertaken to create individual OT activity plans. We found evidence in the care records that activities are being offered and taking place, and that patient's likes and dislikes were explored with them and their relatives/carers to ensure activities offered were meaningful to each individual.

The physical environment

The layout of the ward consists of twenty-four single rooms each with en-suite facilities. At the time of our visit refurbishment work was underway to upgrade en-suite bathrooms. We saw that efforts had been made to personalise bedrooms. Each bedroom had a coloured door which resembled a front door with the opportunity for patients' names and a meaningful picture to be added to aid orientation.

The ward was bright and spacious and we were able to see that efforts had been made to make it feel homely and inviting. There was plenty of seating around the ward for patients to use and signage to orientate them to specific areas in the ward. There were sensory stimulating wall mounts to occupy patients around the ward. There is a lounge area and two separate dining area for the patients.

There is a ward garden which is accessible from the ward and contained good seating and use of space.

The ward also has a dementia café and we heard that prior to Covid-19 this was used on a monthly basis for carer support groups. It is hoped that this is something that will commence again as restrictions continue to ease.

Summary of recommendations

1. Managers should review the level of input to the ward from the consultant psychiatrist to ensure all patients are reviewed on a regular basis

2. Managers should ensure there are comprehensive detailed records entered on the electronic patient management systems by all medical staff

3. Managers should ensure all disciplines are represented at or have the opportunity to provide input to MDT meetings.

4. Managers should give consideration to developing a robust process to ensure information from GP consultations are able to be directly added into the Trakcare record

5. Managers should ensure medical staff refresh their knowledge of the Adults with Incapacity (Scotland) 2000 Act code of practice 3rd edition to ensure compliance with part 5 of the act and an audit of certificates and treatment plans is undertaken on a regular basis

6. Managers should ensure there is a clear process to identify when there is a welfare proxy in place and ensure this is documented clearly and accurately.

7. Managers should ensure processes are in place to support relative/carer/proxy involvement in care decisions and this evidence clearly documented.

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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