Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 24, University Hospital Monklands, Monkscourt Avenue, Airdrie ML6 0JS

Date of visit: 8 September 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.

Ward 24 is a 20-bedded acute admission unit caring for male and female patients with a diagnosis of dementia, often in the advanced stages of their illness, experiencing extreme stress and distress behaviours. On the day of our visit there were 10 patients on the ward; there are some patients that require a larger space and are not able to share dormitory bed areas due to the level of their distress and resultant behaviours.

We last visited this service on 6 June 2019 and made no recommendations.

On the day of this visit we wanted to to hear how patients and staff have been managing as the restrictions around the pandemic have begun to lift and to see how they are managing with such an acutely ill patient group. We are aware families have, at times, struggled with restrictions on visiting and communication, in general, with services.

Who we met with

We met with, and reviewed the care of eight patients, all eight of whom we met with in person. We also spoke with one of relative of an expatient.

We spoke with the service manager, the senior charge nurse, the lead nurse and the occupational therapist for the ward.

Commission visitors

Margo Fyfe, senior manager (practitioners), west team

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

Throughout the visit we saw kind and caring interactions between staff and patients. The staff we spoke with knew the patient group well. The patients that we met with, who could express themselves, praised staff. It was clear to see that there was good leadership in the ward; the current senior charge nurse has been in post since December 2021 and has worked hard at ensuring the staff work as a team with high standards of care and values.

We spoke with one relative of a patient who had recently moved on from the ward. They praised staff for their care and treatment but suggested that communication with families could be improved to ensure families feel fully involved in decision-making, especially in regard to discharge planning. We were informed that efforts are made to involve families as much as they wish and that there is an appreciation of how difficult it is for families to cope with the high levels of stress and distress of their loved ones on the ward.

Since we last visited the ward they have moved to a new electronic record system, MORSE. We were provided with temporary login details for the day that allowed us to fully view patient records. We found the system easy to navigate. We were informed that staff are managing the new system and find it an improvement on the last system which was described as cumbersome.

We were pleased to see that multidisciplinary team (MDT) notes continue to be well recorded on the new system. They detail attendees and include information on what is discussed, as well as clearplans indicating future needs and where appropriate discharge plans. We heard that families are invited to attend these meetings and that they are given the option to join the meetings in person, by telephone or video link.

The ward continue to use formal biopsychosocial models of understanding distressed behaviours, mainly the Unmet needs model. We heard that a former Senior Charge Nurse has been working alongside the psychologist to support staff and ensure the model is being used appropriately as part of a test of change. This role is also provided by trainee doctors that rotate into the ward six-monthly on supervised placements. We were told that this project has made a positive difference to levels of stress and distress of patients. The psychologist has two sessions ofdedicated time per week in the ward. During this time they see patients as well as supporting staff, by providing training in therapeutic care approaches.

Nursing notes continue to be written on the 'situation, background, assessment, review' (SBAR) model, which ensured that there was continuity in notes, and reflection on the patient's progress throughout the day. It was good to see some life history information being progressed for patients. We discussed the importance of this work and the need to ensure this is completed as fully as possible for each patient so that the information can accompany the patient when they leave hospital. We were pleased to note that family/carers are being encouraged to contribute to this information. We hope to see this in place for each patient when we next visit.

We were also pleased to see detailed care plans that were person-centred and covered both physical and mental health needs. However, we found there to be inconsistency in the detail

of care plan reviews. We discussed the need for the reviews to fully reflect the patient journey and any changes to their care needs. We suggested that care plans should change as reviews detailed changes in care needs and interventions, and that this should also link clearly to MDT discussions. We also found that at times phrases were used without any explanation as to what they mean, such as "distraction techniques" and "under an AWI". We recommend that an audit of the care plan reviews is carried out to ensure that they reflect the work being done with individuals towards their care goals and that language used is clear and descriptive, as well as ensuring the reviews are consistent across all care plans.

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 carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient's progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

The ward has an MDT consisting of nursing staff, psychiatrists, occupational therapy staff, psychology staff and is supported by the advance nurse practitioner (ANP) team from 5pm-9pm on weekdays and from 9am-9pm at weekends. The ward has a dedicated ward 24 junior doctor (Clinical Fellow) working all weekdays 9am-5pm. Referrals can be made to all other services as and when required. It was good to note that families are invited to attend these meetings. We noted that social work and community staff are invited to attend where appropriate, when a patient is moving towards discharge.

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. We were assured that family members wishing to attend, but not keen on using the online facility, will continue to be given the opportunity to attend in person.

Use of mental health and incapacity legislation

On the day of our visit, two of the 10 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Most documentation pertaining to the Mental Health Act and the Adults with Incapacity (Scotland) 2000 Act (AWI), including certificates around capacity to consent to treatment, were in place in the paper files and were up to date. We were unable to locate paperwork pertaining to power of attorney (PoA) where this was in place and discussed with staff the need to ensure the paperwork is handed in to the ward before the role can be recognised.

Part 16 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. The one patient on a compulsory treatment order was awaiting a second opinion doctor visit, in order for a certificate authorising treatment (T3) under the Mental Health Act, to be put in place where required.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of AWI must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found all patients had these certificates in place appropriately.

Recommendation 2:
Managers should ensure that staff are asking for copies of powers where PoA or guardianship is in place.

Rights and restrictions

Ward 24 continues to operate a locked door, commensurate with the level of risk identified for this patient group. There is a policy in place and patients and relatives are informed of the need for the locked door on admission. It was good to see information on the ward at the entrance for all patients and visitors to view.

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

We heard about the efforts of nursing staff to ensure there has always been activities available on the ward for patients throughout the pandemic. There is currently only one occupational therapist covering four wards, so her time tends to be caught up in assessments rather than in activity provision. However, we heard that there ongoing considerations, around moving an occupational therapy assistant into the ward, to help boost activity provision.

The Jackie Pool model is in use to assess individuals' abilities and interests in regard to activities. Clinical support workers are trained in the use of this model, and documentation held in a separate folder is clear and easy to access. There is a poster on the wall near the entrance to the ward describing how the model works and the outcome process. We found activity participation notes were also held in daily nursing notes.

We saw several activities happening during the visit. In particular, we saw staff and patients using new technology screens that stimulate the brain and facilitate patient interaction. Patients appeared to be enjoying the activity and we look forward to hearing how this has been embedded into ward activity at future visits.

The physical environment

The ward is situated on the lower level of a large district general hospital. The ward has five single rooms and five three-bedded dormitories. The communal areas of the ward consist of a lounge, a small sitting room/activity space, an activity area, a dining room and enclosed garden.There is a large room that is utilised for family visits and for families to use if they need to remain on the ward with a relative who is in end of life stage of their illness and requires palliative care

The ward is bright, and has space for patients to sit and to rest in the corridor as well as in the communal rooms. Signage is dementia friendly, as are colour scemes on walls, hand rails and in bathrooms, in line with the national dementia standards. One area of concern noted is the flooring. The flooring is not dementia friendly and can, due to colour and pattern, be confusing for dementia patients. We were told of patient falls as a direct result of the flooring and would urgently recommend this issue is addressed by managers.

We saw one of the areas used for visitors and were told how this space is adaptable for the use of family members, where needed, to remain with a terminally ill patient which provides a small space for them at a difficult time in their lives.

There was an enclosed garden space specifically for Ward 24 patients. There were several seating areas and raised bedding plant areas. Patients were encouraged to use this space, weather permitting;there are staff present when the garden is in use, to ensure patient safety

We were told of plans to change a roomin the ward to a staff room, for staff to change into uniforms and have lockers for their belongings. We were told about and saw the current area out with the ward that is used for this purpose. It appears in a poor state of décor with ongoing issues with one of the toilets. We would hope that managers prioritise the changes to this area to ensure staff are appropriately looked after in the work environment.

Recommendation 3:
Managers should urgently address the flooring concerns in the ward to ensure patient safety.

Any other comments

During the pandemic restrictions, staff worked hard, supported by infection control guidance, to contain the outbreaks of Covid-19 in the ward. We also heard about the effect of the pandemic on staffing and the ongoing issues in recruiting trained staff, as in many areas across the mental health estate. This is an issue the Commission have highlighted to Scottish Government.

In the past we had been concerned about patients being on the ward for extended periods of time as delayed discharges. We were pleased to hear that at the time of our visit there were three patients with identified placements to move on to in coming weeks and currently no patient identified as delayed dischages with no placement identified for them.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patient's progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Managers should ensure that staff are asking for copies of powers where PoA or guardianship is in place.

Recommendation 3:
Managers should urgently address the flooring concerns in the ward to ensure patient safety.

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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