**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Willow and Oak Wards, Orchard View, Inverclyde Royal Hospital, Larkfield Road, Greenock PA16 OPG

**Date of visit:** 19 April 2023

## 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.

Oak Ward is situated in Orchard View on the Inverclyde Royal Hospital site. It provides care for 12 adults with complex care needs. Willow Ward is located in the same unit and is a 30-bedded ward that provides assessment and treatment for older adults who have complex care needs. On the day of our visit, there were eight vacant beds in Willow Ward, while Oak Ward had 11 patients.

We last visited Oak Ward on 8 June 2021 and Willow Ward on 28 September 2022 and made recommendations in relation to care planning, audit processes and covert medication pathways.

The response we received from the service was that these issues had been actioned.

For this visit, we wanted to follow up on the previous recommendations and to look at the use of the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the management of informal patients. This is because potential differences in the threshold for use of the acts had been highlighted to us by the local mental health officers (MHO) group.

## Who we met with

We met with, and reviewed the care of 13 patients, all of whom we met in person. We also met with one relative.

We spoke with the service manager, the senior charge nurse and charge nurse, senior occupational therapist and psychologist.

## Commission visitors

Mary Hattie, nursing officer

Mary Leroy, nursing officer

Mike Diamond, social work officer

Justin McNicholl, social work officer

# What people told us and what we found

Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patient group well. It was good to note that the patients and the relative that we spoke to were positive about staff.

## Care, treatment, support and participation

### Multidisciplinary team (MDT)

The wards have a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, and psychology staff. Willow Ward has operated without a senior charge nurse (SCN) in place for some time, however this vacancy has now been filled on a fixed-term basis, and an additional Band 6 nurse has been appointed. There were registered nurse vacancies across the wards that have been filled by bank and agency staff. The patient activity co-ordinator (PAC) post had been vacant for some time; however this has now been appointed to and the new PAC will be working across both older adult wards (Willow and Ward 4 of the Larkfield unit) . We were told that a creative arts therapist had also been appointed and will have sessional input to the unit. There is sessional physiotherapy input to a small number of patients, however the service manager advises that more patients could benefit from physio input if there was increased availability. Referrals can be made to all other allied health professions and specialist teams as and when required.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings. We saw evidence of proxy decision-makers and carers being invited to MDTs.

**Recommendation 1:**

The level of physiotherapy input should be reviewed to ensure this is adequate to meet the clinical need and provide maximum patient benefit.

### Care plans and records

Information on patients care and treatment was held in two ways. There was a paper file which contained the admission notes, some risk assessments, care plans, Do Not Attempt Cardio Pulmonary Resuscitation forms (DNACPR's), power of attorney (PoA) and guardianship papers with section 47 certificates where required. The electronic record system EMIS held the chronological notes, craft risk assessments, MDT reviews and mental health act paperwork.

Risk assessments were comprehensive and had been reviewed through the MDT process. However, care plans varied considerably and it was disappointing to see little change since our last visit.

In Oak ward there was clear evidence of patient involvement in care planning and care plans were person-centred. However, the review process was mixed; a number of reviews simply stated no change and some were focused and meaningful.

In Willow Ward we found completed "getting to know me" forms in the patients' files that we reviewed. This document contains information on an individual's needs, likes and dislikes, personal preferences, and background, to enable staff to understand what is important to the

individual and how best to provide person-centred care whilst they are in hospital. However, in some of the care plans that we reviewed, this information was not incorporated or it did not address all the identified needs or risks for the patient. Some plans were not dated. We found Newcastle formulations in place for patients who were experiencing stress and distress. This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. However, these were not referenced or fully reflected in the care plans.

We found confusion in the care plans regarding DNACPRs. Some did not address the inclusion of the DNACPR and instead claimed that the patient was for resuscitation. We were disappointed to find that the standard of care planning that we had previously found on our visit to Willow Ward had not been maintained.

Care plans had not been reviewed for some months, and as a result, the legal status of one patient was wrongly recorded in the care plan.

Chronological notes in both wards were clear and relevant and included information on activity participation and carer/relative involvement.

Both wards used the Mental Health Combined Care Assurance Audit Tool, (MHCCAT), a peer review audit tool. However, we found several inaccuracies in the audit information recorded, with several items scored as achieved when we found that this was not the case with our review of the records. We also noted that the tool did not address the issue of person-centred care.

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 2:**
Managers should regularly audit care plans to ensure they are person-centred; address all the identified risks and needs, contain accurate information and are meaningfully reviewed on a regular basis.

**Recommendation 3:**
The use of the MHCCAT should be reviewed and training provided to ensure consistency and accuracy in the peer audit process.

## Use of mental health and incapacity legislation

On the day of our visit, three of the 22 patients in Willow ward and 10 of the patients in Oak ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. However, one T3 certificate did not cover all

prescribed medication. This was highlighted on the day and the consultant was contacted to review this.

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 Act 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 section 47 certificates in place for all individuals we reviewed who required one. Proxy decision makers had been consulted, however one of the certificates had expired three months previously.

Both these issues were raised with the service manager and the charge nurse during the visit.

**Recommendation 4:**
Medical staff should audit to ensure that all prescribed medication and treatment is properly authorised under the relevant act.

## Rights and restrictions

Willow Ward continues to operate a locked door, commensurate with the level of risk identified in the patient group. Oak ward operates an open door policy. During our visit we noted that informal patients were advising staff that they wished to leave the ward and they were allowed to do so.

There was open visiting across both wards. Visits take place in patients own rooms, the small sitting rooms and the garden areas.

There are good links with advocacy services who visit the wards when required.

Where specified person restrictions were in place under the Mental Health Act we found completed forms authorising this.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their 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 from patients in Oak Ward that there were music sessions, walks, discussion groups and “cups of tea and a chat” with the occupation therapists (OTs); we found evidence of activity provision in the chronological notes in both wards, with good evidence of OT involvement. We were told activities are patient-led and vary depending on the individual patient’s preferences; there was no set activity programme available at the time of our visit. However, we heard that when the new PAC comes into post, there will be opportunities to increase activity provision in a more structured way and this will be further enhanced by the

input from the creative arts therapist. We look forward to seeing the impact of this on our next visit.

## The physical environment

Both wards are bright, clean, spacious, and benefit from access to enclosed courtyard gardens and a larger garden space that surrounds much of the unit. All bedrooms are single room with en-suites. There were several small sitting rooms that enabled patients to have a choice as to where they spent their time. There was a multipurpose activity/crafts room that was shared by both wards.

In Oak Ward there was a degree of personalisation of the patient's bedrooms, where they had their own bed coverings, pictures etc.

In Willow Ward we saw personal pictures and items in bedrooms and several had memory boxes situated outside bedrooms that were filled with personal items and pictures.

## Summary of recommendations

**Recommendation 1:**
The level of physiotherapy input should be reviewed to ensure this is adequate to meet the clinical need and provide maximum patient benefit.

**Recommendation 2:**
Managers should regularly audit care plans to ensure they are person-centred; address all the identified risks and needs, contain accurate information and are meaningfully reviewed on a regular basis.

**Recommendation 3:**
The use of the MHCCAT should be reviewed and training provided to ensure consistency and accuracy in the peer audit process.

**Recommendation 4:**
Medical staff should audit to ensure that all prescribed medication and treatment is properly authorised under the relevant act.

## 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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