mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on unannounced visit to:

East and North Wards, Dykebar Hospital, Grahamston Rd, Paisley PA2 7DE

Date of visit: 27 May 2024

Where we visited

East and North Wards provide care to older adults with complex care needs which cannot be met in other settings; East Ward provides care for females and North Ward for males. The wards are located in Renfrewshire.

Each ward has 21 beds in single bedrooms with en-suite facilities. There is an assisted bath and toilet in each ward. On the day of our visit, there were 20 people on East Ward and 19 on North Ward.

We last visited this service in November 21 and January 2022 on announced visits and made recommendations in relation to care planning, the recording of proxy decision makers, provision of psychology, and the environment.

For this visit, we wanted to follow up on the previous recommendations and look at activity provision.

Who we met with

We met with, and reviewed the care of 11 people, all of whom we met with in person. We also met with three relatives.

We spoke with the senior charge nurses, the lead occupational therapist and physiotherapist, as well as members of the nursing team and the operational manager.

Commission visitors

Mary Hattie, nursing officer

Gemma Maguire, social work officer

Paul Macquire, nursing officer

Matthew Beattie, ST6 higher trainee in psychiatry

What people told us and what we found

All the relatives we spoke with were very positive in their views about the experience of care of their family member while on the wards. We heard that despite staff being very busy, they were always welcoming and kept relatives informed and involved in care decisions. One relative spoke about being supported to remain actively involved in their spouse's care and how important this was to them. One individual said that staff looked after their loved one well, made them feel safe and always had time for a chat and a laugh.

Care, treatment, support and participation

Care records and delivery

Information on patients' care and treatment was held in three ways; there was a paper file, the electronic record system EMIS, and the electronic medication management system, HEPMA. Care plans and nursing reassessments were held in the paper system. Multidisciplinary team (MDT) reviews and chronological notes were held on EMIS, along with Mental Health Act paperwork. The health board is in the process of transitioning across to a fully electronic system.

In the care plans we reviewed, we found that risk assessments were documented and reviewed regularly. We also found completed Getting to Know Me documentation in the files. This provided information on an individual's preferences, needs, background and likes and dislikes that enabled staff to understand what was important to the individual. Care plans were person-centred and addressed both physical and mental health needs. These were regularly evaluated and in the majority of cases, care plans were updated to reflect changes in presentation and care needs.

We were pleased to see improvements in care planning since our previous report. However, we did find one care plan in East Ward which erroneously stated the individual was informal when they were subject to detention under the Mental Health Act, and, in North Ward we reviewed the care of several individuals where a recommendation had been made for discharge. We were unable to find discharge plans setting out what actions had been taken or were still required to facilitate the discharge.

In both wards we found that where individuals suffered from stress or distress, detailed and informative Newcastle-type formulations were in place. The Newcastle framework and process was developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge. We found detailed formulations setting out potential triggers and that provided information on each individual's management.

In East Ward there were five individuals on continuous observations and two in North Ward. We heard that this level of clinical activity was not unusual, and often required the use of bank staff to maintain safe staffing levels.

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 care plans to ensure these accurately reflect the legal status and current care needs of the individual, setting out clearly the interventions required.

Multidisciplinary team (MDT)

We were told that there had been challenges in recruiting consultant psychiatrists over recent months. As a result of this, there have been a number of months where consultant cover was provided either by a distant locum consultant or by consultants from other areas taking on additional responsibilities.

Both wards now have dedicated input from locum consultant psychiatrists and a specialty doctor provided GP cover, and attends the ward Monday to Friday. There is dedicated occupational therapy (OT) and an OT technician, physiotherapy and pharmacy input. The ward is currently without psychology input, the previous psychologist having left in the last month. The vacant post was being recruited to and it was hoped that psychology input would recommence in the near future. Social work are involved on a case-by-case basis. Input from speech and language therapy, dietician, other allied health professionals and specialist services was available by referral.

MDT reviews were recorded on the EMIS electronic record keeping system. MDT meeting notes provided a summary of each individual's recent presentation and care needs, however in East Ward, these did not always include a record of who was in attendance at the MDT meeting. In both wards, there was a lack of clarity around decisions taken and actions required.

The requirement for NHS hospital care is reviewed on a regular basis. We heard that relatives and proxy decision makers were invited to reviews on a three-monthly basis, and if unable to attend, their views are sought and recorded.

Recommendation 2:
Managers should audit MDT meeting records to ensure that these contain a record of attendance and of decisions taken and actions required.

Use of mental health and incapacity legislation

On the day of the visit, seven people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was in place.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

All patients had a section 47 certificate in place to authorise their treatment under the Adults with Incapacity (Scotland) 2000 (the AWI Act).

Where the individual had granted a power of attorney (POA) or was subject to a guardianship order, details of powers granted and the contact details of the proxy should be held on file. In

East Ward we were unable to find a copy of the POA document on file for one individual who we were advised did have a POA in place. Where a proxy was appointed copies of the powers were available in all of the other files we reviewed.

Recommendation 3:
Managers should audit to ensure that where there is a proxy decision maker copies of the powers are on file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate 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. However, one of the s47 certificates we reviewed in North Ward was out-of-date, having expired the previous month. For one individual in East Ward, we were unable to locate the section 47 certificate. Both these issues were raised with the senior charge nurses at the time and we asked that they be highlighted to medical staff for action.

Recommendation 4:
Managers should audit to ensure that where an individual lacks capacity to consent to treatment a section 47 is completed to authorise treatment.

Rights and restrictions

The doors to both wards are secured by a keypad entry system. Visitors exit and enter with the assistance of nursing staff. There was information about this on display near the door and during our visit we observed that staff responded promptly to visitors.

Open visiting was in place in both wards. Visitors could visit in the small sitting rooms, the garden areas or the individual's bedroom and could also use the grounds or take their relative out should they have wished to do so.

Advocacy was available and this information was on display, however we were told that no patients were currently making use of this service.

Activity and occupation

There was a varied activity programme in each ward provided by the occupational therapist and therapy technician. This included a range of small group and individual activities to meet the needs and preferences of the individuals, such as the development of life stories, reminiscence, quizzes, games, exercise, film events, music groups and the use of playlists for life for individuals, virtual visits with families etc.

Individuals were also supported to attend church services on a virtual basis. There were regular therapet visits and music was provided on a weekly basis by the Wandering Minstrel. We saw individuals engaged in a quiz and in an impromptu singing session during our visit.

Nursing staff spend time in informal activities, chatting with individuals and taking them for short walks around the ward and grounds. The physiotherapist and occupational therapy technician do a joint exercise group weekly in each ward. We found good evidence of activity

preference and participation in the notes we reviewed for both wards. In East ward, there was a weekly choir group and North ward had football memories sessions. We heard that East Ward currently does not have a regular hairdresser attending, but that a replacement was currently being sought.

The physical environment

Both wards have the same basic layout, which comprises of 21 single en-suite bedrooms. We noted personalisation in a number of bedrooms, with family pictures and personal items on display. There is dementia friendly signage throughout both wards.

Each ward has a small, quiet sitting room and an activity room, both with direct access to a secure level garden area with covered seating that provided a very pleasant and useable outdoor environment. Unfortunately, both gardens have been neglected and there are a lot of weeds growing up between the paving stones, making it both unsightly and a trip hazard.

The activity rooms were well used for breakfast and lunch groups as well as various group and individual activities. On the corridors there were several activity boards and pictures of sporting celebrities and local scenes.

The main sitting and dining area sits at the crossroads of the corridors in the central hub of the ward, with several bedrooms off this area. As a result, these areas are busy thoroughfares. Natural light is provided via a large skylight; we were told by staff this can make the wards uncomfortably hot in summer. There were no other windows in these areas. Attempts have been made to mitigate the lack of windows with murals of outside scenes and pictures, to add interest to the walls. However, as the majority of people spend much of their day in these areas where there is no external view, we do not feel the wards provide a suitable environment to meet the needs of the client group.

We are aware that the older adult's mental health service review is ongoing and look forward to seeing the conclusions from this with regard to the estate.

Recommendation 5:
Work should be undertaken to address the neglect of the garden areas and bring these up to an acceptable and usable standard.

Any other comments

We were advised by the senior charge nurses that there have been occasions over recent months when, due to pressure on beds in adult services, patients from South (adult acute) Ward have been boarded into East and North Wards overnight, to accommodate emergency admissions. On discussing this with the operational manager it was acknowledged that this is not acceptable on an ongoing basis.

We were informed that the management team are addressing this with the medical team and bed managers to find an appropriate solution.

Summary of recommendations

Recommendation 1:
Managers should audit care plans to ensure these accurately reflect the legal status and current care needs of the individual, setting out clearly the interventions required

Recommendation 2:
Managers should audit MDT meeting records to ensure that these contain a record of attendance and clarity around decisions taken and actions required.

Recommendation 3:
Managers should audit to ensure that where there is a proxy decision maker copies of the powers are on file.

Recommendation 4:
Managers should audit to ensure that where an individual lacks capacity to consent to treatment a section 47 is completed to authorise treatment.

Recommendation 5:
Work should be undertaken to address the neglect of the garden areas and bring these up to an acceptable and usable standard.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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