Mental Welfare Commission for Scotland

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

Date of visit: 18 June 2024

Where we visited

Maple Villa is a 14-bedded unit for men with a diagnosis of dementia who experience high levels of stress and distress. Individuals are generally admitted from the Livingston general practice (GP) catchment areas.

The unit is located in the Craigshill area and adjoins to the recently closed local authority Craigmair interim care home facility. Along with Rosebury Wing from Tippethill House Hospital in Armadale, it has been identified in future proposals for relocation to the vacant care home facility next door. Further proposals include moving Bailie Wing from Tippethill into the unoccupied unit.

Although more usually for those over the age of 65, Maple Villa has in the past admitted younger men with early onset illness. On the day of our visit, there were eight people requiring 24-hour care; there were six vacant beds.

Since our last visit, bed capacity had reduced from 24 to the current 14. We were advised that the reduction was made as the ward no longer met the criteria for hospital based complex clinical care (HBCCC) and no longer had the 'footfall' for the additional beds.

We made an unannounced visit to the service in May 2022, making a number of recommendations, which we wanted to follow up on with this visit.

Recommendations included reviewing the level of input from psychiatry to ensure regular reviews of individuals; that all medical staff should record comprehensive records into the electronic patient management system; that information from GP consultations were directly added to the TRAKCare record; that all disciplines were represented at multidisciplinary meetings; that medical staff refreshed their knowledge in relation to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act); that a clear process to identify the welfare proxy and to support relative/carer involvement were implemented.

The response we received from the service was that it was felt the current level of psychiatry input was appropriate for the patient numbers and that this was being reviewed as part of a wider review of psychiatric resource. A proforma was created for GPs to record consultations and care actions which would then be uploaded onto sci-store on the electronic information system, TRAKCare. Invitations were extended to all professionals for multidisciplinary/family meetings and where unable to attend, they would be offered opportunities to provide reports.

The management team felt confident that medical staff were aware of the requirements of the AWI Act following appointment of a new consultant psychiatrist and relevant paperwork would be audited. With the allocation of a specific social worker, improvement to systems were proposed to identify where proxies were

appointed. There was no response indicated for our final recommendation relating to relative/proxy involvement.

Who we met with

Prior to the visit, we had a virtual meeting with the acting senior charge nurse (A/SCN) and general manager (GM). We heard that the consultant psychiatrist had recently retired, and a locum psychiatrist was providing cover. We were also informed that the senior charge nurse (SCN) had very recently left post, and that the deputy charge nurse (DCN) was covering responsibilities pending the recruitment to this post.

We met with two relatives and another relative, who was unable to meet us during our visit, provided feedback via telephone. We had opportunities to meet the occupational therapist (OT), nurses, health care support workers (HCSW), the activity co-ordinator and student nurses.

We also reviewed the care records of four people. We were pleased to learn that the DCN had recently been appointed as the substantive SCN and heard of their plans to make improvements to the service.

Commission visitors

Denise McLellan, nursing officer

Jo Savege, social work officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit, we met with several people however, we were unable to discuss their care in depth with them due to the progression of their illness. We were reassured to see that the individuals appeared settled, and throughout the day we witnessed staff interactions with individuals that were warm, friendly, and attentive.

Relatives told us that they were "very happy with the care" their loved one was receiving and that they felt very much involved. They confirmed they were consulted, and their views were sought to assist care planning, with a "good level of sharing information." We were also told that staff were accessible and responsive when they had any questions at all. One relative/carer told us that they had been invited to and attended a family meeting, adding that they felt "lucky" that their father was now settled and well looked after and said "nothing ever feels like a problem" for the staff. Relatives/carers that we spoke with confirmed that staff understood their additional role as power of attorney (POA).

Specific praise was given about the activities co-ordinator who included them on a local walks with their family member, remarking that they appreciated being able to spend time in the open surrounded by nature and wildlife, given that this had been one of their relative's favourite places to be. They expressed concern that their relative would need to be moved to a care home in the future but acknowledged that they felt "listened to" by staff in relation to this and were grateful for the support provided, saying they were regularly asked how they were and offered time to chat during visits.

Another relative contacted the Commission to provide feedback after receiving a letter about our visit. They had been unable to meet us on the day, however, were keen to inform us about the "wonderful care" their relative received. They described the complex physical and mental health needs of their relative and how the staff were "wonderful" and provided an excellent level of care which was a great comfort. They praised how staff involved him in activities, such as spending time in the garden and watching football, also commenting on how supportive staff had been towards them.

We spoke with the activity co-ordinator who told us that they had "the best job in the ward". They spoke enthusiastically about their role and support they received from the wider team and the NHS Lothian volunteer service. This support included having 'protected time' to continue to undertake their duties. Quite often when clinical need was high, staff were redeployed to cover deficits in other areas. We were told managers worked hard to avoid doing this, as they had a clear understanding about the impact of the role and benefit for individuals. They spoke of positive feedback received from others about the difference being made, including how staff could

easily recognise whether someone had been actively engaged in activities during the day as the effects were noted in the person's overall presentation and mood for an extended period.

Nursing staff told us that having a smaller number of patients afforded them the opportunity to better get to know the people in their care and their family. They were conscious that the ward environment felt calmer, more settled, and less noisy. It also enabled quicker identification of changes and deterioration which happened quite frequently, due to physical health problems such as infection.

We heard that staff remained with the service for a long period of time; one person we spoke with had worked on the ward for ten years. We got a sense that people enjoyed their jobs, and we were told that training was actively encouraged for HCSWs, with learning opportunities in areas such as tissue viability training, physical health monitoring and venepuncture.

Daily staff meetings took place, which provided an opportunity for reflecting on what had gone well, actively seeking solutions and improvement. We were also made aware by others of the effective communication between the professional disciplines and how that the team were open to new ideas.

Care records

Patient data was held on the electronic information system TRAKCare, which was relatively easy to use. Some documentation was also stored separately in paper format, including mental health legislation, authority to treat certificates, section 47 certificates, and do not attempt cardiopulmonary resuscitation forms (DNACPR). We considered this a helpful back up system given the 'stand-alone' nature of the unit and ensured access to information was readily available in the event of technical issues.

A whiteboard in the nurses' office also held information about individuals' detention status and whether they were subject to other legislation. Staff were aware that regular monitoring of this was necessary, to ensure this information was updated and accurately reflected the most current available. We noted an example where the information on the whiteboard did not reflect what was in the records. We highlighted this to the SCN who amended this immediately.

We found evidence of engagement with families and information that informed the care provided; this was gathered in documents such as 'getting to know me' and 'what matters to me'. We were told that the team met formally with relatives every three to six months and spoke with them regularly on the phone and when they visit the ward.

Documentation also captured how individuals presented prior to and after visits.

Overall, record keeping was of a good standard and the language used in the continuous notes was positive, respectful, and supportive. There was evidence that staff knew the patients well however, there was no documentary evidence of one-to-ones discussions between individuals and staff, other than those written by the activity co-ordinator. We were told that one-to-ones happened regularly and informally, so while these were happening, this was not being reflected in the care records.

Recommendation 1:
Managers should ensure that there is a regular audit process in place to ensure that one-to-one discussions between individuals and nursing staff are taking place regularly and clearly identified in the notes.

There was evidence of regular physical health care monitoring and associated assessments, such as the malnutrition universal screening tool (MUST) and national early warning score (NEWS). We were told that risk assessment was continuous and saw examples of weekly reviews in the records. We were advised that GPs were not directly accessing TRAKCare to upload entries following consultations. We were told that a further service level agreement had recently been signed and that training would be accessible electronically, with any additional training that was required supported by the team to remedy this.

Nursing care plans
Care plans were person-centred and used positive, inclusive language. There was evidence of participation with the individual and family, including a record of what limited obtaining information directly from individuals. We were pleased to see that care plans told a mini story of the person informed by observations from family, friends and staff, including those who worked in Maple Villa and information gathered from previous services.

We found comprehensive care plans that covered a broad range of needs and there were regular reviews happening. We were told these were audited weekly by the SCN. There were good examples of stress and distress plans with detailed information including 'what calms, what soothes me' in a 'my calm card'.

There was also a sensory preference assessment which included visual, sound, hearing, touch, smell, taste, movement and pressure. For one individual there was personalised and helpful information about their sensitivity to noise and how this could be alleviated to reduce their stress.

Multidisciplinary team (MDT)
Our last visit highlighted that MDT meetings were only regularly attended by the consultant psychiatrist and nursing staff. Since then, a dedicated social worker has linked in with the team and attended all MDT meetings. In addition to this, the OT

attended where they had specific information to feed back in relation to assessments and discharge planning. MDT meetings were held fortnightly with half of the individuals on the ward reviewed at each meeting; all individuals were reviewed by a psychiatrist on a minimum monthly basis.

We enquired about psychological input but were told that there was no provision into the unit however, referrals could be made to the West Lothian psychological approach team 'Welpat' for support with distressed behaviour. Referrals could be made to other allied health professionals such as physiotherapy and speech and language therapy on an individual basis. The addition of an activity co-ordinator has been in the last year and heard positive feedback on the difference this was making to individuals' lives; we suggested they could be invited to attend MDT meetings.

We were advised of a shortage in older adult consultant psychiatrists and that following recent retirement, a locum was covering this vacancy. We were disappointed to see that the frequency of medical reviews had not increased and heard from nursing staff that they could contact the on-call psychiatrist for advice between meetings if necessary. It was considered that the current level of psychiatry input was appropriate for the patient numbers. We were advised that this would be evaluated as part of a wider review of the psychiatric resource. Proposals including other wards relocating to the one site envisioned increasing MDT input across the service. The GP service had twice weekly visits to the ward and staff could use NHS 24 outwith GP hours.

The MDT proforma provided a template that set out the agenda for reviews and included information on attendees. It also contained details on legal status, physical health, family involvement, and risk updates with outcomes and proposed actions arising from discussion. Although MDT meetings were scheduled on a fortnightly basis, we were unable to find recorded details for one. We discussed this with the SCN who initially thought this could be due to a record not having been made of the meeting due to staff leave coinciding with a crossover between the retirement and recruitment of the new locum consultant psychiatrist. We heard that previously, meetings would be attended and documented by the SCN or DCN however, they planned to address this and delegate the task to band 5 registered nurses.

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 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained and are either capable or incapable of consenting to specific treatments. We were advised at our pre-visit meeting that one T3 certificate authorising treatment was outstanding, and that a designated medical practitioner visit for a second opinion had been requested.

Prescriptions were written on a paper kardex, with relevant T2/T3 certificates held alongside them. We were unable to find a T3 for one person and were told this had been highlighted to responsible medical officer (RMO) in April however, due to an administrative error this had not been actioned but was now being dealt with. We were offered assurance that this had been escalated to the RMO and a designated medical practitioner (DMP) visit requested in order for this to be put in place.

Section 243 of the Mental Health Act allows medical treatment to be given to a detained patient without consent if deemed to be required urgently. A T4 certificate which records that medication has been given for this is then completed and sent to the Commission. We discussed a specific issue with the SCN in relation to this and asked them to liaise with the RMO about the need to complete a T4 certificate, as appropriate. We will follow this up.

Another request had been made for an individual transferred from another ward on the previous day. We found that the existing T3 certificate did not authorise one medication prescribed on the kardex. We were told that this had been added by the GP after the T3 certificate had been completed. The SCN agreed to highlight this to the RMO for actioning.

Recommendation 2:
Managers should ensure that there is a regular audit process in place to ensure that all psychotropic medication prescribed is legally authorised within the appropriate timescale.

We found covert medication pathways in place for some individuals but noted a lack of a review date and were concerned that this would create the risk of reviews being missed. There was also no information for some individual in relation to which professionals had been involved in the decision-making process.

The Commission has produced good practice guidance on the use of covert medication.

Recommendation 3:
Managers should ensure that there is an audit process in place to ensure that any medication given covertly is reviewed regularly.

All documentation relating to the Mental Health Act was available on TRAKCare and highlighted on the white board. The SCN also informed us that they would be recommending a review of the compulsory treatment order (CTO) in place for one individual given the view it was potentially no longer necessary, as the individual had been increasingly settled and another legislative framework was in place with relevant powers.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (the AWI 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. Documentation was reviewed, and we were pleased to see that improvements had been made since our last visit and the recommendation that had been made. There was detail in the section 47 certificates and all had treatment plans attached and most cases, detailed consultation with the family and POA.

We were pleased to find a good example documenting family contact arrangements where the POA was shared, and this explained who the main contact was and how the ward should make contact with them to share information. However, we found that one POA certificate was not the registered copy on file and there was no document which confirmed activation of the POA as stated in the activation clause. We highlighted this to the SCN to follow up with the family.

DNACPR certificates, with exception of one, were completed correctly, however, one did not have the names of the POA recorded. This was highlighted to the SCN who confirmed that this would be brought to attention of medical staff. We noted many of these issues observed related to documentation that had been carried over from transfer from other areas. We suggested an audit of documentation on admission.

Recommendation 4:
Managers should ensure that there is a system in place to audit records so that any discrepancies can be highlighted and actioned at the earliest point in the admission process.

The whiteboard had a column for 'AWI' which the SCN confirmed was for section 47 certificates. It was recommended that the board be amended to use more rights focused language e.g. changing ‘AWI’ to section 47 certificate and be more specific about POA/welfare and financial guardianship status. The SCN agreed with these suggestions.

Rights and restrictions

Maple Villa continued to operate a locked door policy, commensurate with the needs and vulnerabilities of the individuals in the unit. This was clearly displayed in the ward, and we also saw evidence of individual risk assessments that identified those who would be at risk due to their vulnerability, if the door were to be left open.

We were told of close links with EARS independent advocacy service, with the advocacy worker attending MDT meetings when necessary. Most people had family involvement, but we found that no referral had been made to this service for someone who did not.

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.

Activity and occupation

Since our last visit, the full-time activity co-ordinator has been added to the team. The usual availability of the activity co-ordinator is between Sunday and Wednesday inclusively, however, there was flexibility where specific activity was needed, such as taking individuals to watch home games at Livingston football club.

Nursing staff provided activity opportunities out with those days. There was also input from the NHS Lothian trainee volunteer service which delivered an additional resource, including four activity volunteers and three gardening volunteers. We were told that this had been available for around one year however, it had developed more recently. Volunteers had 'Disclosure Scotland' clearance and were easily identified by their purple uniform. There was a helpful board on display carrying pictures and descriptions to explain their purpose and help people to identify them.

A variety of equipment was available in the activity room which also housed a large projection screen for the 'cinema club'. People could watch films of relevance to them aiding reminiscence, 'dipping in and out' depending on their ability to concentrate. There was also a dementia café where families could participate in activities that added the benefit of helping to prompt conversation with individuals.

We visited during the Euro 2024 football tournament and noted much of the activity planner focussed on this theme. We were reassured however, that other activities were still available including arts and crafts, gentle exercises, walks and music therapy.

The ward had ongoing access to a therapet and 'music in hospitals' times annually, as well as visits from the generation arts project every three months. People were supported to enjoy familiar interests, such as visiting the local supermarket, going out for breakfast rolls and walking groups. There were also different themes pursued each week, for example, attending football matches and going to see retro car displays. We found entries in the notes detailing activities offered, including when these were declined.

Often, the families' recent memories could have been related to having to manage and care for their loved one at home in increasingly stressful circumstances, where their family member was experiencing high levels of stress and distress. Family participation was actively encouraged, and we were pleased to hear that there were opportunities to go for walks with individuals alongside staff and volunteers. We were told that this increased confidence and enjoyment for all.

The physical environment

The ward layout consisted of 14 single bedrooms with en-suite facilities. Bedroom doors resembled front doors and were individualised by different colourways with identification markers, such as pictures and names displayed to assist orientation.

Whiteboards in each room contained helpful information taken from the 'getting to know me tool'; it was personal and practical and included individual's preferences gathered from the assessment process.

The environment was spacious and following the decrease in patient numbers, one of the dining areas was repurposed to make an additional activity area. There was plenty of seating arranged along the wide corridors, allowing people to walk/roam but rest when needed. The lighting varied in some areas of the ward which made it appear quite dull and we raised this at our meeting at the end of the visit. The SCN confirmed that this had been reported and the senior manager suggested this would be escalated if not resolved.

Individuals had the use of a peaceful, accessible, enclosed and private garden. It contained ample seating, and the space was used well. There was a range of plants and additional features, such as bird feeders for people to enjoy nature close by. The garden was very well maintained and supported by the efforts of the three volunteers.

In addition to people having TVs in their own rooms, there was a lounge area where they could watch TV together. There was a separate dining area, and a room designed and equipped as a barber's shop, where individuals could have their hair trimmed.

Bedrooms and communal areas were spotlessly clean. Unfortunately, there was a lack of bright and stimulating artwork as all the pictures had been pulled from the walls. We saw that information boards had to be moved behind glass at the entrance to the ward so that they could still be read, but not damaged. Efforts had been made to soften the area by laminating pictures and placing them around the corridors. Commission visitors observed the use of decals in dementia units elsewhere to counter this specific issue and these seem to be more difficult to remove.

Any other comments

We were encouraged to hear feedback from relatives and staff about the positive relationships that have developed. It was evident from what we observed and from discussions with staff that there was an enthusiasm for, and knowledge about, those they cared for. We were pleased to hear that training was inclusive and that roles were valued and respected with consideration given to 'ring fencing' activity provision. We hope that the newly appointed SCN and team will be supported to continue to develop the service further.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a regular audit process in place to ensure that one-to-one discussions between individuals and nursing staff are taking place regularly and clearly identified in the notes.

Recommendation 2:
Managers should ensure that there is a regular audit process in place to ensure that all psychotropic medication prescribed is legally authorised within the appropriate timescale.

Recommendation 3:
Managers should ensure that there is an audit process in place to ensure that any medication given covertly is reviewed regularly.

Recommendation 4:
Managers should ensure that there is a system in place to audit records so that any discrepancies can be highlighted and actioned at the earliest point in the admission process.

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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