mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Muirton Ward, Seafield Hospital, Barnhill Road, Buckie, AB56 1EJ

Date of visit: 30 January 2020

Where we visited

Muirton Ward is an older adult assessment ward for people with dementia. It has eight available beds and on the day of our visit there were eight patients in the ward. We last visited this service on 7 February 2018 and made recommendations around the prescribing of medication for informal patients, the use of 'as required' medication, recording of activities, and the physical environment.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of six patients and one relative.

We spoke with the senior charge nurse (SCN), charge nurse, and the lead nurse.

Commission visitors

Tracey Ferguson, Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit we saw positive interactions between the staff and patients. The ward was calm and the staff responded quickly to patients when they needed assistance. The relative that we met with told us that staff treated their relative with kindness and respect, and that nursing staff were approachable.

On reviewing files we found detailed assessments that contained good life history information. There were detailed risk assessments along with risk management plans in place for each patient. We found that care plans were detailed and daily reviews of each care plan were recorded in the patient notes. Care plans covered a wide range of holistic needs and included detailed interventions for stressed and distressed behaviours.

Although the care plans were reviewed daily, we saw that there was no overall summative evaluation.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We found that some files had *Getting to know me* booklets completed with help from relatives and for recent admissions we saw it recorded in files that staff were attempting to try and gather this information.

The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf).

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

Where we saw 'do not attempt to cardiopulmonary resuscitation' (DNACPR) forms in file, we found that there was a lack of recording and consultation where a person had a legal proxy in place to make welfare decisions

We were told by the managers that six patients had been assessed as ready for discharge from hospital. We wanted to find out what progress or active planning was happening for the patient. We saw detailed multidisciplinary team (MDT) meetings which took place weekly. These included recorded actions/outcomes for each patient. We found that in some patients files there was variation of detail in the outcome section of the MDT minute and we discussed this further on the day with the managers. Some files had recorded 'delayed discharge', so it was difficult to know from the MDT minute the active planning that was happening. However,

from reviewing the files, we were satisfied that there was active planning occurring for all patients.

We saw recorded on the MDT minute who attended the meetings; however there was lack of recording as to who and how the outcomes/actions were being taken back to the patient if the patient or their representative did not attend the meeting. We discussed this further with the managers on the day.

Where it had been recorded that an Adults with Incapacity Case Conference was required as part of their discharge planning process, we found that these meetings were often happening once a patient had been assessed as being ready for discharge. We were told that this was having an impact on the patient spending further time within the hospital setting and also impacting on admissions to the ward.

We discussed this further with the managers on the day and recommended further discussions with the community services around arranging these case conferences early on in the patient's admission, where appropriate.

For patients who had covert medication pathways in place we saw appropriate documentation in place along with timescales for reviews.

We were told that the ward now has a pharmacist who attends the MDT meetings and reviews the drug kardexs for each patient.

Recommendation 1:
Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

Recommendation 2:
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Use of mental health and incapacity legislation

On the day of our visit four patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Mental Health Act paperwork within records was well maintained and was easy to access within files.

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. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order as appropriate apart from one patient who had been prescribed medication that was not authorised on the T3 form. We brought this to the attention of the managers on the day.

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') we saw copies of the legal order in place apart from one file. We brought this to the manager's attention on the day.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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. We saw that most patients had a S47 completed. There was, however, a lack of detail and variation in the completion of the accompanying treatment plans for patients.

Recommendation 3:
Managers should ensure that treatment plans are completed in accordance with the AWI Code of Practice (third edition).

Rights and restrictions

The external fire door to the ward was locked to maintain safety and to prevent patients leaving the ward unnoticed. All staff had a key should the door need to be unlocked in an emergency. Although the door to the ward was locked, this was not causing any undue concerns to patients and the locked door policy was on display. We were told that the ward has good links with the Circles Advocacy project and advocates will visit patients on the ward, in meetings, at tribunals, and as part of discharge process.

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

Since our last visit we wanted to follow up on the recommendation that was made around the recording of activities. The SCN told us that the ward staff continue to provide activities. There is a weekly timetable of activities in place and the activities are now being recorded in a separate activity folder. We viewed this folder and saw recording of the activities being provided. We felt that detail around the benefit of this activity was lacking in detail and discussed this further with the managers on the day. From reviewing files, we felt that perhaps all activity was not being captured in this folder. Although the ward staff provide regular activities on the ward we were also told that the patients have access to weekly art therapy if they wish and that pet therapy visits the ward regularly.

The ward has developed one of the dormitory rooms into an activity room where there was a bright display of paintings and drawings on the ward. Ward staff told us that patients enjoy the art therapy sessions.

The physical environment

The ward was bright and spacious with plenty of options for patients to mix with others, or to spend time in a quiet area. With the ward being spacious, we saw that this provided patients with the ability to walk around safely. There was a combination of dormitory and single room bed areas allowing for a degree of flexibility according to needs and wishes. There was

dementia friendly signage helping patients to find their way around. There was also a large conservatory and dementia friendly garden.

We wanted to follow up on our recommendation on our last visit regarding the flooring. The managers told us that the flooring has not been replaced and that this continues to be risk assessed. Soft flooring has been put in some of the patients rooms which staff feel has helped. We were told that there are ongoing discussions about the need for a purpose-built ward for the future but were given no timescales around this. We would like to be informed of any progress around the development of a purpose-built new ward and will write to managers about this.

Summary of recommendations

1. Managers should ensure that nursing staff include summative evaluations in patient care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

2. Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

3. Managers should ensure that treatment plans are completed in accordance with the AWI Code of Practice (third edition).

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.

ALISON THOMSON
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 MWC 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.

Contact details:

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

telephone: 0131 313 8777
e-mail: enquiries@mwcscot.org.uk
website: www.mwcscot.org.uk