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VISIT AND MONITORING REPORT

Recommendations and outcomes from our local visits 2017

OCTOBER 2018

Contents

Our mission and purpose

Our local visits

One way we achieve our mission is through local visits to particular services or facilities. We undertake local visits for various reasons. Some facilities, for example secure units, are more restrictive on individuals' freedom and we visit them more often as a consequence.

Our visits are not inspections and we do not grade services. An inspection looks very closely at particular national and local performance standards. While we want to know if people are receiving the standards of care they are entitled to, we do not measure against particular standards. The Care Inspectorate carry out inspections to registered care services and Healthcare Improvement Scotland inspect some hospitals.

Our visitors do take into account any applicable national standards and good practice guidance, however. Our findings and the recommendations we make will reflect on established good practice as appropriate (such as national health and social care standards, dementia standards for Scotland etc.) but also include the observations we make on the day of the visit, the professional expertise and judgement of our visitors and what people we met with told us.

We share information with other key scrutiny bodies—the Care Inspectorate (CI), Healthcare Improvement Scotland (HIS) and Her Majesty's Inspectorate of Prisons for Scotland (HMIP). We meet regularly with them and the information shared helps us to decide where we should prioritise our visits.

We are members of the Sharing Intelligence for Health and Social Care Group, one of seven contributing national agencies that shares and considers intelligence about the quality of care systems across Scotland.[1]

Copies of all our local visit reports are published on our website, sent to the CI for visits to care homes, and to HIS for NHS services and independent hospitals. Copies of our reports to prisons are sent to HIS and HMIP.

We want to make sure that these organisations are aware of any concerns that we have raised as they may choose to look further at these.

Our local visits are not the only time when we visit people in hospitals, care homes and prisons. We often visit at other times during the year to meet with those who are subject to mental health and incapacity legislation. We also carry out national themed visits where we will visit individuals in similar services across the country then report on our findings.

[1] www.mwcscot.org.uk/media/377262/sihcg_annual_report_aug2018.pdf

How often we visit

The frequency of visits to people in a particular service is based on information from a variety of sources and can be increased or decreased depending on the intelligence we receive. Our focus on the visit will depend on the type of facility and the information we have. We aim for at least 25 percent of local visits to be unannounced and visit within NHS Scotland:

- Adult acute admission wards on an annual basis
- Child and adolescent mental health (CAMHS) in patient wards on an annual basis
- Other specialities e.g. perinatal inpatient, eating disorder units, every two years
- Dementia assessment wards on an annual basis
- Dementia continuing care wards every two years
- LD assessment wards on an annual basis
- LD continuing care wards every two years
- Adult rehabilitation wards every two years
- High secure wards(State Hospital) twice a year
- Medium secure hospitals on an annual basis
- Low secure hospitals, not less than every 18 months
- Prisons every two to three years

We visit independent hospitals after discussion with HIS. We no longer routinely visit care homes on local visits but will do so if it is appropriate and after discussion with the CI.

Between 1 January 2017 and 31 December 2017 we carried out 101 local visits and we made 278 recommendations relating to these visits. This is an increase from 2016 when we carried out 94 local visits.

About our recommendations

When we make recommendations, we allow the service manager three months to formally write to us with their response. If the recommendation is particularly serious and urgent we will reduce the response time accordingly.

Once we receive the response it is allocated to the Commission officer who coordinated the visit to decide if the response is adequate or if we need further information. We will check on any future visits to see that the recommendations were implemented as planned. If we find that our recommendations have not been adequately addressed then we will escalate our concerns to senior managers.

To make sure our recommendations are being acted on, we introduced a new process to manage responses to our recommendations and provided service managers with guidance about what they need to include in their response.

We then consider when the next visit is required dependant on the nature of the recommendation and the service's response.

This visit year we expected an acceptable response to at least 90 percent of the recommendations we made. We were satisfied that services had responded appropriately to 92 percent of our recommendations. At time of reporting, we had not received responses to 18 recommendations. These have since been received but are not included in the forthcoming analysis.

Looking closely at the recommendations we make to particular types of services helps us to determine our future visiting priorities and what we need to focus on during our visits. It also helps us to determine if we need to carry out a particular themed visit or develop good practice guidance.

This report looks at where we were most likely to make recommendations and what they were about. We also give some examples of where improvements have been made and which may be of interest to other services across Scotland.

Where we visited

Chart 1: Number of services visited (1 January 2017 to 31 December 2017)

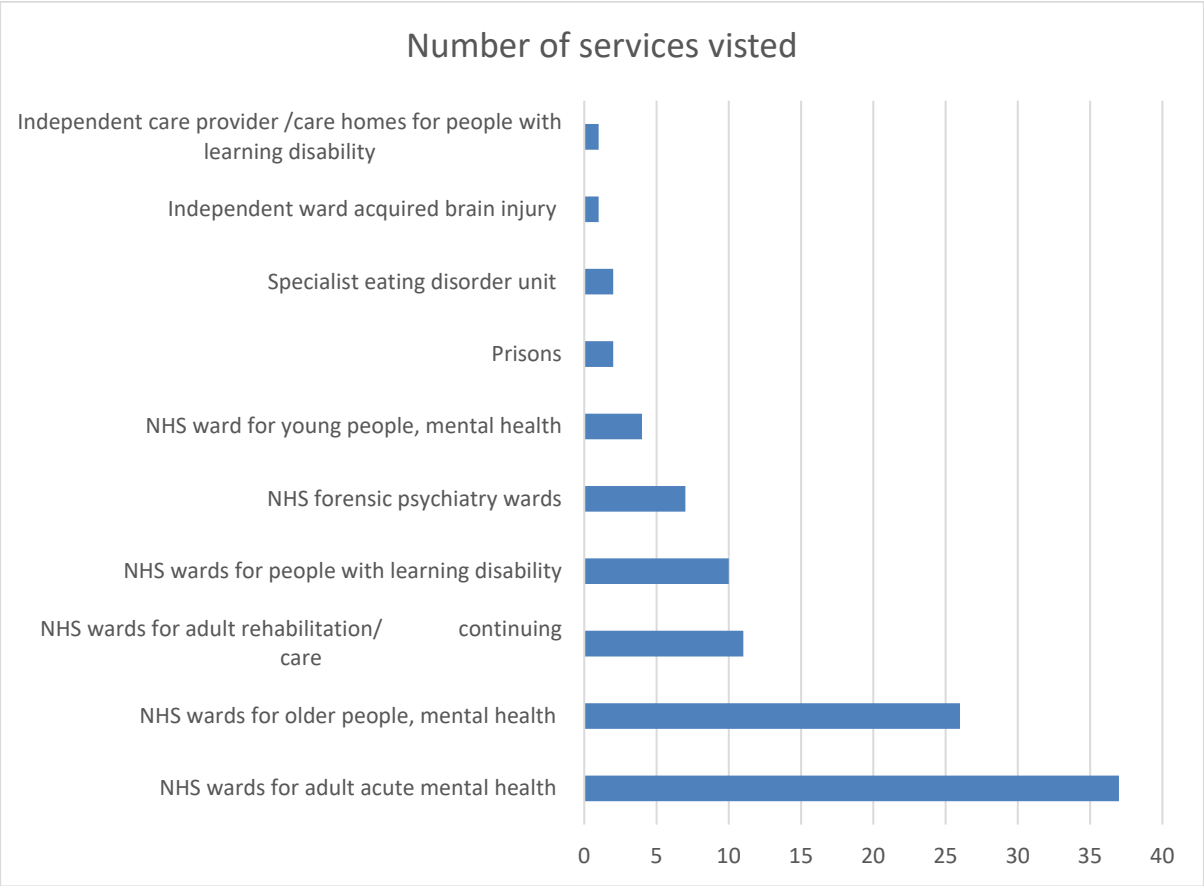


Table 1: Types of services – number of services visited and recommendations (1 January 2017 to 31 December 2017)

	Services		Recommendations	
	No.	**%**	**No.**	**%**
NHS wards for adult acute mental health	37	36	93	33
NHS wards for older people, mental health	26	25	74	27
NHS wards for adult rehabilitation/continuing care	11	11	33	12
NHS wards for people with learning disability	10	10	33	12
NHS forensic psychiatry wards	7	7	20	7
NHS ward for young people, mental health	4	4	6	2
Prisons	2	2	6	2
Specialist eating disorder unit	2	2	8	3
Independent ward acquired brain injury	1	1	2	1
Independent care provider /care homes for people with learning disability	1	1	3	1
Totals	**101**	**100%**	**278**	**100%**

The above table includes seven visits where no recommendations were made.

NHS wards for adult acute mental health were the largest grouping, representing 37 percent of visits, generating the majority of recommendations over the visit period.

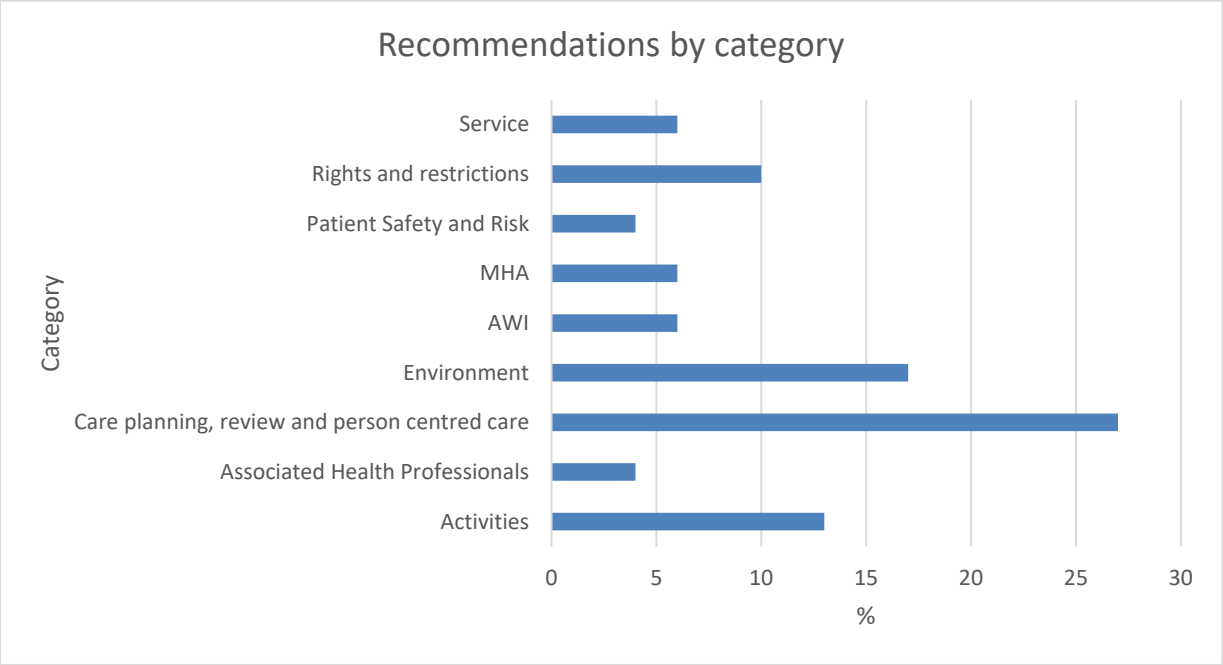
Previously we routinely visited care homes as part of our local visit programme but now only visit where we have discussed with the CI and identified a clear focus for our visit. We continue to visit individuals in care homes on other visits we carry out e.g. for individuals subject to incapacity legislation (welfare guardianship). We will be reviewing our frequency and focus on visits to prisons later this year.

Recommendation category

Table 2: Number of recommendations by category (1 January 2017 – 31 December 2017)

Recommendation category	Total	%
Care planning, review and person centred care	74	27
Environment	47	17
Activities	37	13
Rights and restrictions	30	10
AWI	17	6
MHA	17	6
Service issues	17	6
Access to Allied Health Professions	11	4
Patient Safety and risk	11	4
Medication	8	3
MHA/AWI/Both	5	2
Carer	2	1
Multi-disciplinary team	2	1
Total	**278**	**100**

Chart 2: Percentages of recommendations by type (1 January 2017 – 31 December 2017)



The distribution of recommendation category across all recommendations is broadly similar to last year.

Care planning, review, and person-centred care

Table 3: Number of care planning, review and person centred care recommendations by service type (1 January 2017 – 31 December 2017)

Type of service	Number of recommendations	%
Older People (NHS)	25	34
Adult Acute (NHS)	19	26
Learning Disability (NHS)	11	15
Rehab wards (NHS)	11	15
Young person's wards/units (NHS)	3	4
Prisons	2	3
Eating disorders(NHS)	1	1
Learning Disability (independent)	1	1
Young person's wards/units (independent)	1	1
Totals	**74**	**100**

This area generated the highest number of recommendations.

Twenty seven percent of all the recommendations we made this year related to assessment, care planning, review, and person centred care—slightly higher than last year when this figure was 25 percent. These recommendations have been combined for the purpose of this report as they can sometimes be difficult to separate out.

Involvement of the individual in his or her treatment and care is an important principle underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003 (The 2003 Act). Care plans are an ideal vehicle to demonstrate that this is occurring. There are many ways of involving the person, even in situations where compulsion is required to ensure treatment is received or participation appears to be difficult to achieve. For people who have additional needs it may be necessary to use varying means of communication to support effective participation.

Care plans are a crucial part of supporting and helping the process of recovery. The process of care planning should enable people to take more control of their lives and ensure that the person's perceived needs and aspirations have been taken into

account. A good care plan will have the individual, not just his or her symptoms, at the heart of it.

Of these recommendations the largest number, 25, related to services for older people. These recommendations were most often about ensuring that care plans were person centred and obtaining and using ‘life story’ information to help with care planning for people with dementia.

In adult acute mental health wards the recommendations were mostly about ensuring a recovery focus.

On our visits we want to see that patients are involved and understand their care plan and we find that the quality and level of patient participation varies considerably.

We often recommended that care plans would benefit from being audited either by peers or managers to ensure the quality of care plans and the documentation that supports them. A common theme was the introduction of electronic care files and the difficulties in accessing key information quickly.

Across our local visits and themed visits, the Commission has repeatedly made a high number of recommendations about the quality of care plans at hospital, care home, and prison visits across the NHS and independent sector. The number of recommendations that we make continues to rise and we feel there has been little progress in this area.

We have received feedback from services and others that good practice guidance would be helpful. We will be consulting later this year on this guidance and plan to publish this in spring 2019. The good practice guidance will focus on the essential components of a care plan, what is meant by person-centred care, and how to encourage and promote participation.

Some examples of our recommendations and responses

We recommended	The service responded
The ward manager and clinical nurse manager should conduct an audit of all care plans and reviews to make sure they are person-centred, individualised, and describes specific interventions in relation to the management of behaviour.	The SCN and CSDM carried out an audit as indicated above. They found that the quality of care planning in relation to being person-centred and detailing intervention to address behaviours was variable. Not all patients had a care plan for meaningful activities, likes, dislikes, or distraction. They found that there was not always a correlation between the level of need and the frequency of reassessment and review. To ensure improvement, the SCN has set out the standard of care planning which allows ward staff to see clearly what is expected. The standard is detailed in the ward induction pack for registered nurses. Three-monthly audits will take place and training will be provided where necessary.
Nurse management and senior charge nurse should develop nursing care plans and include more individualised interventions, as well as an evaluation of each intervention when the care plan is reviewed. These should include evidence of patients' own views of their own goals and aspirations for their care and treatment and rehabilitation.	The ward established a working group and has identified a collative approach based on the CHIME model. Training needs for staff have been identified which are being addressed through education slots which all staff are attending. Staff are now working on a collaborative approach to care planning with patients to establish goal based care plans. We can now evidence patient involvement with care plan evaluation. Individual patient information packs are in the late stages of development and will include patients' own care plans.
Managers should ensure that work to develop a specific care plan audit tool and to develop the focus on person centred planning is prioritised.	A short-life working group was established to develop a person-centred care plan audit tool. The audit tool was implemented as a pilot within BSIU and

	focus groups were facilitated to evaluate the effectiveness of the audit tool. The plan is to use the audit tool across all Learning Disability In-patient areas. A short-life working group is being established to review the care planning process across learning disability in-patient services. The expected outcome will be that care plans will be more person-centred, more user friendly, and will identify personal preferences and wishes and how they may be achieved.

Physical environment

Table 4: Number of recommendations by service type (1 January 2017 – 31 December 2017)

Service type	Number of recommendations	%
Older People (NHS)	18	38
Adult Acute (NHS)	16	34
Rehab wards (NHS)	8	18
Forensic wards (NHS)	2	4
Learning Disability (NHS)	2	4
Prison	1	2
Totals	**47**	**100**

This year 17 percent of the recommendations related to aspects of the physical environment where those we visited were living, a slight increase on last year. Most of these recommendations related to making sure that repairs and maintenance were attended to, and making sure that garden areas were accessible and well maintained.

Adults with Incapacity (Scotland) Act 2000

Table 5: Number of recommendations by service type (1 January 2017 – 31 December 2017)

Service type	Number of recommendations	%
Older people (NHS)	10	59
Adult acute wards (NHS)	3	18
Learning Disability (NHS)	2	12
Learning Disability (independent)	2	12
Totals	**17**	**100**

We want to know that people are receiving treatment in line with the law, particularly in relation to Part 5 of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act). This Act provides important safeguards for people.

Six percent of all our recommendations related to the 2000 Act, the majority to services for older people both in care homes and hospitals. This is a notable decrease on last year where 11 percent of all recommendations made related to the 2000 Act.

The majority of recommendations we made in this category related to making sure that those with proxy decision making powers (powers of attorney and guardians) were clearly identified in care notes along with the powers granted.

We also made recommendations to ensure that Section 47 certificates were easily accessible to nursing staff. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the 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 2000 Act.

We also recommended that where medication was administered covertly that this was properly authorised and followed best practice principles as detailed in our good practice guidance.[2]

[2] Covert medication; Mental Welfare Commission 2017
www.mwcscot.org.uk/media/140485/covert_medication.pdf

The Commission has produced helpful guidance notes for staff working with the 2000 Act in care homes[3] and has published guides specifically on the subject of power of attorney[4] .These can be found on our website.

Mental Health (Care & Treatment) (Scotland) Act 2003

Table 6: Number of recommendations by service type (1 January 2017 – 31 December 2017)

Service type	Number of recommendations	%
Adult acute wards (NHS)	7	41
Older people (NHS)	4	24
Forensic wards (NHS)	3	18
Learning Disability (NHS)	1	6
Forensic wards (independent)	1	6
Rehab (NHS)	1	6
Totals	**17**	**100**

Six per cent of our recommendations concerned the Mental Health (Care & Treatment) (Scotland) Act 2003 (The 2003 Act). This is the same percentage as last year. Adult acute (NHS) wards accounted for 41 percent of all recommendations made in relation to the Mental Health Act.

The Commission has a duty to monitor the operation of the 2003 Act. One of the ways we do this is by visiting people subject to various provisions of the 2003 Act. On our local visits we meet with everyone who wants to meet with us. Our role is in relation to all people with a mental illness or learning disability, those subject to the 2003 Act and those not.

We check to make sure that no one we visit is subject to unauthorised deprivation of liberty and those who are subject to the Act have all the necessary safeguards in place, including completion of required documentation.

[3] Working with the Adults with Incapacity Act: Information and guidance for people working in adult care settings (2007) http://www.mwcscot.org.uk/media/51918/Working_With_The_AWI_Act.pdf
[4] Common concerns with powers of attorney: November 2017 www.mwcscot.org.uk/media/233718/common_concerns_2017.pdf

Most of the recommendations in this category related to documentation and consent to treatment provisions of the Act.

The Commission has produced good practice guidance on these provisions, and they can be found at https://www.mwcscot.org.uk/publications/good-practice-guides/.

Both Adults with Incapacity (Scotland) Act 2000 and Mental Health (Care & Treatment) (Scotland) Act 2003

A small number of recommendations (five) related to both Acts. These concerned ensuring consent to treatment certificates and access to documentation was easily available.

Therapeutic Activity

Table 8: Number of recommendations by service type (1 January 2017 – 31 December 2017)

Service type	Number of recommendations	%
Adult acute wards (NHS)	14	38
Older people (NHS)	7	19
Learning Disability (NHS)	6	16
Rehabilitation wards (NHS)	4	11
Forensic (NHS)	3	8
Young people's wards (NHS	2	5
ABI (independent)	1	3
Totals	**37**	**100**

Thirty-seven of the recommendations made this year concerned the provision of therapeutic activity—13 percent of all recommendations made. This is similar to last year's findings where the figure was 10 percent.

Activity and occupation should be viewed as an essential part of care and treatment and not an optional extra, particularly when people are in hospital or care home for an extended period of time.

Of these recommendations, approximately a third related to NHS adult acute wards. These tended to relate to a lack of recording of participation in and the outcome from any activity.

Although provision of recreational and therapeutic activities was often good during the week, it could be limited at evenings at weekends and we recommended managers address this.

Some examples of our recommendations and outcomes

We recommended	The service responded
The charge nurse, nursing, and OT staff should prepare a separate activities care plan for patients and they should be regularly reviewed and evaluated with the patient.	The ward team have established a daily 'coffee club' which generates community activity planning each day and plans ahead for events the next day. A standard operating procedure is in place to support the delivery of this activity. Each patient now has an activity recording chat. An adapted screening tool is in place. An 'interest checklist' and 'individual goal setting form' are being developed. A standard operating procedure is in place for daily goal setting.
Hospital managers should ensure there is an adequate provision of activity at weekends.	All wards have an activity programme in place for out-of-hours and weekends to provide therapeutic and social engagement. However this is dependent on clinical activity and there are times this activity programme can be disrupted during critical or emergency situations or periods of high clinical activity. Nurse page-holders will now be supernumerary at weekends and plans are in place to recruit ward clerical support which will release nursing time for direct patient care. We will recruit three additional therapeutic activity nurses to provide ongoing activities at weekends and in the evenings.

Patient Safety and Risk

Table 9: Number of recommendations by service type (1 January 2017 – 31 December 2017)

Service type	Number of recommendations	%
Adult acute wards (NHS)	6	55
Eating disorders	3	27
Learning Disability (NHS)	1	9
Rehabilitation wards (NHS)	1	9
Totals	**11**	**100**

Four percent (11) of recommendations referred to patient safety and risk. The majority related to the risk assessment and management of the physical environment in adult acute wards. We will be liaising with the Health and Safety Executive and other key organisations to promote a consistent national approach the management of risk.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