**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:** North and East Ward, Dykebar Hospital, Grahamston Road, Paisley PA2 7DE

**Date of visit:** 7 May 2019

## Where we visited

North Ward has 21 en-suite bedrooms, and provides care for men with dementia who require continuing NHS care due to their complex needs. East Ward has 20 beds and provides care for females with dementia and complex care needs. At the time of our visit, both wards were full with six patients subject to measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

We last visited on 6 December 2011 and made recommendations relating to life story information and person-centred care, covert medication and activity provision.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and also look at use of the Adults with Incapacity (Scotland) 2000 Act ('the AWI Act'). This is because it provides the legal framework and safeguards for much of the care of individuals who lack capacity.

## Who we met with

We met with and/or reviewed the care and treatment of 13 patients and three carers/relatives.

We spoke with the senior charge nurse, charge nurse, speech and language therapist, and other members of the nursing team.

## Commission visitors

Mary Hattie, nursing officer

Mary Leroy nursing officer

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

## What people told us and what we found

### Care, treatment, support and participation

Both wards have input from a consultant psychiatrist and a specialty doctor. There is regular input from physiotherapy, occupational therapy, speech and language therapy, and other allied health professionals are available on referral.

There are weekly multidisciplinary team (MDT) meetings. The ward is in the process of moving from paper records to electronic records. Currently, chronological notes of care and MDT meetings are recorded on the 'Emis' system, which is the electronic record system being introduced. We found that the MDT notes varied considerably in quality, with some failing to indicate who was in attendance at the meeting, and having

little detail about decisions take, whereas others gave a much fuller account, including consultation with relatives or proxy decision makers.

There was evidence of regular evaluations of care plans. However, the care plan was not updated to reflect the outcome of the review, and as a result care plans were missing important information gathered since admission, and did not reflect patients current care needs and interventions.

The majority of patients whose care we reviewed did have a completed ‘Getting to Know Me’ on file. This is a document which records a person's needs, likes and dislikes, personal preferences and background, and is aimed at helping hospital staff understand more about the person and how best to provide person-centred care during a hospital stay. Life history information varied considerably with some patients having very detailed life stories on file, while other patients had little or no information recorded.

**Recommendation 1:**

Managers should audit records to ensure that MDT meeting notes contain information on who attended, decisions taken and any discussions with relatives/proxies.

**Recommendation 2:**

Managers should ensure that care plans are person centred and contain life history information.

**Recommendation 3:**

Managers should audit care plans to ensure they are updated following evaluations to reflect any changes in the individuals care needs.

## Use of mental health and incapacity legislation

Where patients were subject to Mental Health Act, the appropriate paperwork was in place to authorise this. However, we found one patient subject to detention under the Mental Health Act, where this was not accurately recorded within the chronological notes. This was highlighted to the charge nurse at the time.

We found one patient had an excellent advance statement in place and this was informing care.

Where patients had a proxy decision maker appointed under the AWI Act, copies of the powers were on file.

Section 47 of the AWI Act authorises medical treatment for people who are unable to give or refuse consent. Under s47, a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity.

We found s47 certificates in place for the patients whose files we reviewed, authorising their treatment under the AWI Act. Where it was recorded that was a proxy decision maker in place, we found evidence that they had been consulted about the granting of the certificate and treatment decisions. However, we reviewed one file where there was a copy of the Power of Attorney on file, but the doctor signing the s47 certificate had ticked the box saying there was no proxy decision maker; as a result they had not been consulted. We discussed this with the charge nurse at the time and asked that this be highlighted to medical staff during the ward meeting that day.

We reviewed the files of several patients who were receiving covert medication. Whilst we found evidence of advice from pharmacy around the administration of medications covertly, covert medication pathways were out of date, missing, or not fully completed for all but one of the patients whose file we reviewed.

**Recommendation 4:**

Managers should audit records to ensure that information on proxy decision makers is accurately recorded and proxies are consulted appropriately.

**Recommendation 5:**

Managers should ensure that where patients are receiving covert medication, there is a covert medication pathway in place to authorise this.

The Commission has produced guidance on the use of covert medication which includes a template covert medication pathway: Covert Medication

## Rights and restrictions

Both wards had doors secured by keypad entry system. Visitors exit and enter with the assistance of nursing staff.

Several patients used pelvic positioners to maintain their position in their chair. Where this was the case, physiotherapy had been involved and there was a risk assessment and care plan in place. This was reviewed at the multidisciplinary meeting. We saw posters for advocacy services within the wards

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/rights-in-mind/

## Activity and occupation

We were told that both wards have regular input from occupational therapy technicians who provide a programme of activities and outings.

There are regular therapet visits and music in hospital sessions, North Ward benefits from football memories sessions and playlists for life are used in both wards, with additional new headsets on order for this. On the day of our visit, several patients were out having lunch with the occupational therapy staff. However, when reviewing the chronological notes, we found very little activity recorded.

Staff advised us that staff are often redeployed to provide cover in other wards, leaving their staffing complement depleted. Due to the high level of clinical activity and the complex needs of their patients, this leaves them with little time to provide any additional ad hoc activities for patients. North Ward advised that, at times, some of their patients experience stress and distress due to lack of stimulation.

**Recommendation 6:**

Managers should ensure that there is adequate staffing resource available to meet the physical needs of the patients, and provide a range of activities to ensure a meaningful day.

## The physical environment

The wards both have pleasant secure garden space directly accessible from the sitting rooms. North Ward has recently benefitted from the installation of a pop-up pub within one of the sitting rooms, and East Ward has a reminiscence room. Both wards had dementia-friendly signage, and bedrooms were personalised to varying degrees. The large central hub of each ward has a large skylight, but no windows with external views. We noted that this is an area where many patients spend the majority of their time.

## Any other comments

The relatives we spoke to were very positive about the ward staff, commenting on the quality of communication and the warmth of welcome they received, as well as the quality of care which their loved ones experienced.

### Good practice

In all records we reviewed where PRN medication had been given, there was a record of its effectiveness one hour after administration. A number of the patients whose care we reviewed had very complex physical needs, and the care plans to address these needs contained a good level of detail.

## Summary of recommendations

1. Managers should audit records to ensure that MDT meeting notes contain information on who attended, decisions taken and any discussions with relatives/proxies.

2. Managers should ensure that care plans are person centred and contain life history information.

3. Managers should audit care plans to ensure they are updated following evaluations to reflect any changes in the individuals care needs.

4. Managers should audit records to ensure that information on proxy decision makers is accurately recorded and proxies are consulted appropriately.

5. Managers should ensure that where patients are receiving covert medication, there is a covert medication pathway in place to authorise this.

6. Managers should ensure that there is adequate staffing resource available to meet the physical needs of the patients, and provide a range of activities to ensure a meaningful day.

## 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.

MIKE DIAMOND
Executive Director (Social Work)

## 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.

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