Mental Welfare Commission for Scotland

Report on announced visit to: Cumbrae Lodge Care Home, Jura and Kintyre Units, Castlepark Road, Irvine, KA12 8SZ

Date of visit: 5 October 2016

V3 -11/5/2016
Proofed, MB 24.10.16

Where we visited

Cumbrae Lodge Care Home provides nursing home care for the population of Ayrshire, including dementia services. The home supports a maximum of 78 older people across six units. We visited Jura and Kintyre units, which provide 26 beds contracted by the NHS; at the time of our visit there were 20 residents placed in these two units. We last visited this service on 8 October 2013, visiting the three units that at that time provided private or local authority-funded care (this has now been increased to four units). We have been advised that care and support provided between all units should be largely identical, though those residents within the all-male Kintyre unit often have more complex needs alongside challenging behaviour.

Following the Commission's visit in 2013 we made recommendations in relation to the consistency and completeness of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) care plans; we recommended that legal papers in relation to the use of the Adults with Incapacity (Scotland) Act 2000 should be retained in care folders; and we encouraged the completion of life stories for all residents.

On the day of this visit we wanted to follow up on the Commission's previous recommendations and also to look at provision of meaningful activity; the role of the keyworker; and care plan assessment, recording and implementation. These latter areas were highlighted within the most recent inspection report from the Care Inspectorate, based on their inspection of 28 June 2016.

Who we met with

We met with and reviewed the care and treatment of 11 residents. We also met with one relative during our visit.

We spoke with the manager and deputy manager; an activity coordinator; nursing staff; and support staff.

Commission visitors

Jamie Aarons, Social Work Officer and visit coordinator

Alison Goodwin, Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Life histories

Since our last visit the care home has now introduced ‘My Journal’ and ‘My Choices’ documents. The latter is a tool used for recording life story information, in addition to residents’ likes and preferences. We found these booklets completed within each of the care files we reviewed. We were pleased to see that care plans and activity planning and provision appeared, as often as possible, to be linked to a resident’s past interests or current preferences.

Care plans

All the care plans we looked at contained a high level of detail and were person centred. Personal preferences and routines were recorded. While the care home does not specifically refer to the Newcastle Model for managing stressed and distressed behaviour, we were impressed with their care planning in this regard. For several of the individuals we reviewed there were care plans that provided staff with clear guidance on how best to identify and prevent antecedents to distressed behaviours, as well as guidance on how best to intervene should a particular resident become upset. Care plans that included intervention strategies were person-centred and included specific interventions for staff to try with consistency.

Activity recording, as well as any information regarding stressed or distressed behaviour, could be found within the ‘My Journal’ booklet for each individual. Care plans are reviewed monthly and there was evidence that changes to care plans had been made accordingly. For example, one individual’s covert medication pathway had been recently reviewed and assessed as no longer necessary; covert medication was therefore terminated and an updated care plan created to reflect the resident’s current medication administration.

Where completed, we noted that anticipatory care plans were person-centred and reflected consultation with residents and relevant others. Where relevant, consideration had been given to residents’ past wishes when their present wishes could not be ascertained.

DNACPR certificates

Since our most recent visit the care home has rationalised their DNACPR paperwork and, where relevant, all are completed on the same form. A sticker on the outside of the care file quickly identifies those residents who have a DNACPR in place. The care home has also implemented an ‘alert card’ within every care file which provides staff with quick awareness to a resident’s DNACPR status, allergies, or particular risk.

We noted that improvement was needed for these cards to be stored consistently within care files, but where used they provide an efficient way for staff to know when a DNACPR is in place.

Multidisciplinary Input

Physical health care needs were being addressed and we found evidence of regular input from general practitioner (GP) services; dental services; continence nursing; and dietetics. There was evidence that referrals have been made, as required, to speech and language therapy; occupational therapy; and physiotherapy. Input from consultant psychiatrists, where relevant, was described as positive and staff felt that they have a good working relationship with the psychiatrists.

Feedback provided to us by a relative regarding the care and support at Cumbrae Lodge was very positive.

Use of mental health and incapacity legislation

Adults with Incapacity (Scotland) Act 2000

Where individuals were assessed as lacking capacity to consent to their treatment, they were being treated under part 5 of the AWI Act. We noted that s47 certificates authorising treatment were on file for all of the individuals whose care we reviewed.

Where individuals have proxy decision makers in place (either guardianship or power of attorney), copies of the powers and legal paperwork were inconsistently on file. We typically found guardianship paperwork to be present but formal documentation regarding powers of attorney was often lacking.

We did find that contact details of the proxy were generally recorded and care home management was generally aware of the proxy decision maker's status. Care files contained the Commission's AWI checklist, as recommended at our last visit, but we found several examples in which the information contained on the checklist did not match the information provided on the legal paperwork. For example, it was common to find every suggested welfare power checked on the checklist when, in fact, few or none of these powers had actually been granted.

We noted in our review of files that welfare proxies were not consistently having their views sought regarding decisions for which they hold powers. We also observed staff seeking medical consent decisions from relatives who were not the guardian or power of attorney. On the day of the visit we emphasised to care home management that staff need to be clear that designated guardians and powers of attorney must have their views sought regarding relevant decisions.

It was noted that some of the files we reviewed still contained paperwork that makes reference to English incapacity legislation.

Recommendation 1:

The manager should ensure that copies of welfare guardianship powers and/or powers of attorney certificates are held and they accurately reflect the proxy powers granted and that relevant staff are aware of same.

Recommendation 2:

Where a proxy has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.

Rights and restrictions

The units visited have a locked door with keypad entry and exit, though this door was noted to be kept unlocked when staff and residents were moving back and forth from the units.
We did not see anyone who wanted to leave being prevented from doing so. We expect that where the exit door is locked that residents who wish to leave and are free to do so can exit and are aware of the means to do so.
The main door to Cumbrae Lodge has keypad entry to maintain the security of the building. The door can be opened from inside by pressing the exit button.

Activity and occupation

The home has the input of activity coordinators providing 90 hours per week of support. Within Jura and Kintyre activities are largely provided on a one-to-one basis, though the home does make use of its mini-bus transport and there was evidence within care files that residents have been on outings for meals, shows, and to visit relatives. Residents also benefit from one-to-one activity sessions such as hairdressing, hand massage, or just spending time chatting, where this is more appropriate to their needs. There are religious services provided by a local minister; residents were observed on the day of our visit attending such a service.

We were advised that staff carers are now taking a more active role in engaging residents in activities, rather than relying on activity coordinators. On the day of our visit we observed staff engaged in painting a resident's fingernails (to the delight of the resident) and listening to music with a resident. We noted evidence of activity recorded in 'My Journal' booklets that was person-centred and consistent with the resident's stated interests.

The physical environment

Cumbrae Lodge as a whole is undergoing refurbishment work and painting was being done in the entryway and corridors connecting the different units at the time of our visit. The units we visited are due to be repainted in the near future. It is intended that residents will remain in the units throughout the refurbishment work being completed. It was acknowledged by management that this may be disruptive for some residents and steps should be taken to minimise any stress or anxiety to residents.

Individual bedrooms were noted to have personal touches, including photographs, soft furnishings and personal items. One lounge space within Jura has been recently redecorated and included a resident's own colourful chair. This lounge was comfortable, calm, and gave a feeling of being within a home environment.

Within Kintyre, plans are in place to develop a conservatory in order to provide additional quiet space. The top lounge of Kintyre is soon to have refurbishment work to convert it into a room specifically designed to promote relaxation and calming. Kintyre currently has a secure, dementia-friendly garden space that is well used and makes use of sensory and tactile items for the residents. Both units' enclosed gardens are accessed by patio doors that can be opened by pressing a flip-bar; these doors are not locked to residents but for safety a member of staff would always be present when any residents are accessing the gardens.

Any other comments

Throughout our visit we witnessed staff interacting in a warm and friendly manner with residents and working flexibly to ensure that their needs were met. We were pleased to see good use made of the floating' member of staff on the day. When one resident required extra input from staff to remain settled, staff appeared to be used in an effective manner to promote person-centred care with continuity. Staff with whom we spoke seemed to know each of the residents well.

We noted the recently-introduced system of one member of staff being explicitly allocated to three or four residents per day. This part of the home's daily routine – aimed at addressing some of the issues raised within the most recent Care Inspectorate report - seems to be promoting 1:1 interactions between staff and residents and provides staff with clear direction about their responsibility for their shift. This includes fulfilling the home's stated goal of involving all staff in activity planning and execution, rather than relying solely on the activity coordinators. These keyworkers are then responsible for recording a resident's daily notes and our observation was that 'My Journal' was being used to good effect.

The relative with whom we spoke commented that staff were always friendly and welcoming.

Summary of recommendations

1. The manager should audit care files and, where relevant, ensure that copies of welfare guardianship powers and/or powers of attorney certificates are held within the individuals' care files. The AWI checklists currently in situ should be audited to ensure that they accurately reflect the proxy powers granted and that relevant staff are aware of same.

2. Where a proxy has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.

Good practice

While visiting the Kintyre unit we observed effective use of a pictorial board to assist residents to make choices. We were pleased to see residents being supported to make as many decisions in their day-to-day lives as possible.

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 The Care Inspectorate.

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