Mental Welfare Commission for Scotland

Report on announced visit to: Ward 2, Stirling Community Hospital, Stirling FK8 2AU

Date of visit: 28 January 2016

Where we visited

Ward 2 is a twenty-bedded mixed sex ward providing care for patients who have a diagnosis or a possible diagnosis of dementia. On the day of our visit there were thirteen patients.

We last visited this service on 29 July 2014 and made recommendations in relation to activities, multi-disciplinary input to the ward, care planning, life histories, compliance with Adults With Incapacity (Scotland) Act 2000 (the Adults with Incapacity Act) s47 (part 5 consent to treatment) and appropriate prescribing of psychotropic medication.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with six patients and two relatives.

We spoke with the consultant psychiatrist, service manager, the senior charge nurse and other nursing staff.

Commission visitors

Susan Tait, Nursing Officer, Visit Co-ordinator

Moira Healy, Social Work Officer.

Care, treatment, support and participation

Care plans

On the last visit it was noted that the care plans in place were not suitable for patients with dementia. It was evident that this is now improved. There were a few that would benefit from more detail, for example there were helpful behavioural management plans for stressed and distressed behaviour which had been compiled by management of aggression team. They were not easy to find in the notes and were not incorporated into the nursing care plans.

Risk and needs assessment

It was difficult to locate risk and needs assessment. In some of the notes reviewed this was absent. It is difficult to envisage how care plans can be devised without consideration to initial assessment.

We noted that there was Do Not Attempt Cardiac Resuscitation (DNACPR) assessments for several patients. They had not all been completed appropriately as there was no discussion with guardians, power of attorneys or relatives.

Recommendation 1

Senior nurse should arrange for a qualitative audit of the care plans to ensure that they are person centred, detailing specific nursing interventions

Recommendation 2

Senior nurse must ensure that all patients have a comprehensive risk and needs assessment to inform care.

Recommendation 3

Medical staff should ensure that DNACPR certificates are completed fully to ensure they comply with DNACPR guidance.

http://www.gov.scot/Publications/2010/05/24095633/11

Use of mental health and incapacity legislation

In the last report there were concerns that s47 certificates had not been completed appropriately. On review of the notes that were looked at all s47 certificates were completed with comprehensive treatment plans.

There was one inpatient who was on a compulsory treatment order (CTO) which was recorded as a Community CTO which was not correct. There was a lack of understanding in relation to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) and the Adults with Incapacity Act. We were told “there are six patients who have been in hospital longer than a year but they are subject to provisions of the Mental Health Act” This was not the case, which raises concerns that patients are being treated as if they were detained when in fact they are not. There were inconsistencies in recording whether patients had a welfare power of attorney or a guardianship in place. Copies of the documentation were not always complete e.g. guardianship certificate was in place but the powers granted were not.

Recommendation 4

Managers arrange for staff training to ensure there is up to date knowledge of the MHA and AWI.

Rights and restrictions

In two of the files we looked at the patients were informal had previously been asking to leave and one had attempted to leave when on a different ward. Careful consideration needs to be given to assessment and the criteria for detention.

Activity and occupation

In the previous report there were significant concerns with regard to activities for the patients in ward 2. This concern remains. The ward has recently received new equipment to facilitate activities. However, due to the lack of input from occupational therapy (OT) or activity staff it was difficult to utilise the equipment and there were no organised activities. It was clear though that nursing staff were trying to provide activities when they were able to. As this issue was raised in the last visit in 2014 and there has been no progress with this it needs to be given a high priority, as the lack of activity is very likely to have had a significant impact on patient's wellbeing. We were told that there was a possibility that a post for an activity co-ordinator may be created.

Recommendation 5

Managers should arrange for an urgent review of organised activities.

The physical environment

In the last report it was noted that some improvements had been made to the environment, but that in our view it remained not fit for purpose. Since then the ward has been painted in a variety of strong colours, which we were told was based on the 'Australian model' which aimed to help with orientation. It did, however, present as very overwhelming and over stimulating. More importantly the ward is large with long corridors and several areas which are difficult to provide good observation. The consultant psychiatrist raised concerns about the environment and in particular with reference to the patient group. This is quite mixed with some very frail vulnerable people and others who present with behavioural difficulties due to their dementia and this presents a high risk to all patients. It is appreciated that there is to be a new build "care village" which is scheduled to be opened in 2017/18, however the current environment remains to be not fit for purpose.

Recommendation 6

Managers should urgently review the current environment to minimise the risk of harm to vulnerable patients

Any other comments

There was evidence of good family liaison with meetings well documented.

There was good physical healthcare.

There were particular difficulties with delays to patients being discharged due to the length of time awaiting guardianship, particularly with private applications. The Commission will follow this up on an individual basis.

Summary of recommendations

Recommendation 1

Senior nurse should arrange for a qualitative audit of the care plans to ensure that they are person centred, detailing specific nursing interventions

Recommendation 2

Senior nurse must ensure that all patients have a comprehensive risk and needs assessment to inform care.

Recommendation 3

Medical staff should ensure that DNACPR certificates are completed fully to ensure they comply with DNACPR guidance.

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Recommendation 4

Managers arrange for staff training to ensure there is up to date knowledge of the MHA and AWI.

Recommendation 5

Managers should arrange for an urgent review of organised activities.

Recommendation 6

Managers should urgently review the current environment to minimise the risk of harm to vulnerable patients.

Service response to recommendations

The Commission requires a response to recommendations 1-4 within three months of the date of this report but for recommendations 5 and 6 a response is required within six weeks.

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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