Mental Welfare Commission for Scotland

Report on unannounced visit to: New Craigs Hospital, Old Age Psychiatry Wards, Torvean, Morar, and Clava, 6-16 Leachkin Road**,** Inverness, IV3 8NP

Date of visit: 12th October 2016

Where we visited

Clava is a 20 bedded unit for the assessment and treatment of older people with dementia. Four bedrooms are en-suite, others are in four bed bays.

Torvean is a 12 bedded unit for the assessment and treatment of older people with dementia and stressed or distressed behaviour. Four bedrooms are en-suite. Four have a toilet and sink.

Morar is a 12 bedded acute assessment ward for older adults with functional illnesses. All rooms are en-suite.

We last visited the wards on 3rd September 2015 and made recommendations about recording instances where staff are unable to obtain personal information, recording ward rounds and keeping guardianship and power of attorney paperwork in current files.

On the day of this unannounced visit we wanted to follow up on the previous recommendations. We had been told by the service since making these recommendations that nursing staff had been reminded that where they have been unable to obtain personal information, included for the "Getting to know me" booklet, that they should record this. The ward round recording sheet was reviewed for its suitability for use in all of the older adult wards. The three wards had now been allocated ward clerk time and the ward clerks had been instructed to obtain all the legal papers and other important documents, including guardianship and power of attorney certificates, for patient files.

Who we met with

We met with and or reviewed the care and treatment of 14 patients. No relatives were available to be interviewed on this unannounced visit.

We met and spoke with the Clinical Area Managers or senior staff nurses for each ward, and the NHS Highland Lead Nurse and Service Manager.

Commission visitors

Tony Jevon, Social Work Officer

Ian Cairns, Social Work Officer

Dougie Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Individuals seen and interviewed appeared to be well looked after and told us they were happy with the support provided by staff.

Across the three wards we found that the care plans were very good. There was often detailed information on specific techniques used to support individuals who were stressed or distressed. Individual plans were detailed and person-centred, and there was clear evidence that they were reviewed. Some individuals in Clava also had financial care plans in files, detailing how finances were being managed.

One individual seen had two files with active care plans in both files. This was clearly a mistake, and was addressed on the day.

There was evidence of good physical health care both in terms of medical and allied health professional input and in detailed reports by the doctors on files seen. The dermatology nurse from Raigmore who happened to be in on the day of our visit wanted to highlight that she feels communication between Clava and her service re one patient has been exemplary.

Staff in Clava have introduced a communication book kept in each patient's wardrobe, which has basic details re their support plan and things they have been doing each day – this is to allow family members visiting to look at this and get a very simple update on their relative's care and treatment. Staff are also asking relatives to complete the "Getting to know me" booklet, and these were in most files reviewed in Clava and Torvean, but not in all of them.

In Morar, because of the different client group, they had not introduced the "Getting to know me" booklet and told us they gather personal information in a different format. However, a person-centred personal history was not found in the files seen, even in one case where a diagnosis of dementia had been made. The Clinical Area Manager agreed to consider using a tool to gather this information where appropriate.

Recommendation 1: Managers should ensure that a personal history which encourages and facilitates communication between the individual and nursing staff is completed.

Discharge planning

We found that 11 patients were formally identified as being delayed discharges. One patient had been ready to move on for over 2 years. We did not think enough had been done to actively progress discharge despite a second opinion in March 2016 confirming the patient was suitable for care home placement.

This was followed up by the Commission on the day, and we learned progress is now being made towards discharge. In another case, a patient had been delayed for over 6 months due to issues relating to another health board area and this was followed up by the Commission.

Despite these examples, there was very little evidence in many of the files looked at of discharge planning, even when the patient was formally considered to be delayed. We were told that discharge planning is always discussed at ward round meetings and relatives, as well as other professionals such as social workers, were involved or invited to discharge planning meetings. However, although ward round meetings were clearly recorded with details of who attended and outcomes on the multi-disciplinary team meeting sheet in Morar ward, these were still poorly recorded in the other two wards.

In Clava, one consultant psychiatrist is trialling a new form for recording these meetings and this appeared to be satisfactory. Other doctors still recorded the meeting in daily clinical notes, but the content and legibility varied. In Torvean the weekly reviews were hard to find in the daily clinical notes and rarely documented attendance.

Recommendation 2: Managers should ensure patients' notes clearly record discharge planning meetings, who was invited, who attended, and the outcome.

Recommendation 3: We recommend that the ward round recording sheet used in Morar ward is customised so that it can be used in all three wards.

Use of mental health and incapacity legislation

Adults with Incapacity (Scotland) 2000 - Welfare Proxies

In many case files we reviewed, where there was a welfare proxy (guardian or power of attorney) in place, details of this had not been recorded fully and copies of the legal documents had not been obtained.

We suggested the use of the Commission's checklist for ease of ensuring guardianship details are contained in individual files. The checklist can be found on our website:
http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf

Recommendation 4: Managers should ensure all Adults with Incapacity (Scotland) Act 2000 guardianship and power of attorney documents and recording of details are in place clearly in patients' files and consultation with proxies is recorded appropriately.

Section 47 Certificates

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) Act 2000 legislation must be completed by a doctor. It must cover all relevant medical treatment the individual is receiving.

We noted that the s47 certificate paperwork and treatment plans were in place, but some lacked evidence of consultation with a guardian/power of attorney or nearest relative, as applicable. In one case the consultation had been with a relative, but not the relative who had been granted power of attorney. In another case, the certificate had been completed for three years even though the individual had only just been diagnosed with mild dementia. The code of practice for Part 5 of the Adults with Incapacity Act says that certificates should authorise treatment for one year only, unless the individual has "severe dementia". We followed up with staff about these cases on the day.

Consent to treatment

Part 16 (sections 235-248) of the Mental Health Act set out the conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. The forms used by the responsible medical officer to record consent or non-consent (T2/T3 forms) must also record a clear plan of treatment.

In all three wards, T2/T3 forms were completed as appropriate. In one case 'as required' medication was being used on an almost daily basis for stressed / distressed behaviour and we asked for it to be reviewed to determine if it would be better to give a regular prescription for consistency of dosage. In another case, the T3 could not be located in the patient's file, or with the drug Kardex, though a copy had been sent to the Mental Welfare Commission.

Covert Medication

When a patient is in receipt of covert medication we recommend that this be included on the Section 47 certificate and that a copy of the s47 certificate, treatment plan, and covert medication pathway be stored with the drug prescription sheet. Covert medication pathways were present as required and properly authorised.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms

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.

DNACPR forms were completed with evidence of discussion with proxies in Clava and Torvean. In Morar these forms are used much less because of the different client group.

Activity and occupation

We found a very good provision of activities in Clava with a team of occupational therapists (OTs) and physiotherapists and assistants providing input, three days a week. There were good examples of activities – for example, people accessing activities in the community, staff using electronic tablets to stimulate activities or discussions. Also, the OTs had put details of what each individual patient likes to do, such as listen to particular music, do a particular game, or talk about a specific subject, in a sheet in the staff handover folder so any nurse in the evenings and weekends can look and see what might help each individual patient engage in some activity.

This contrasted with a lack of coordinated activities in the other two wards. In Torvean, there was no OT input and an activities co-ordinator had retired and not been replaced. In these two wards it is left to nurses to provide any ward activities. Due to sickness and recruitment shortfalls in Torvean, nursing staff struggled to provide activities.

There is an activity centre next to Morar ward which is not easily accessible to the other wards and for individuals in Morar able to access this centre a good range of activities are available on a daily basis.

We were given feedback on the day that the OTs are meant to be providing equal input to Torvean and that the service manager is working to make the spread of activities more equitable across the three wards.

Recommendation 5: Managers should ensure that in all three wards activity care plans are person-centred, reflecting the individual's preferences, and patients are supported to take part in identified activities specific to their care needs.

The physical environment

All three ward areas are planned for relocation, and renovation of the new wards pending the move has been more or less completed. Staffing issues, contracts and recruitment have been addressed and the moves should be starting soon. Meanwhile, Clava and Torvean wards remain poorly suited for their purpose – with few single rooms, some ensuite, shared dormitories, and limited lounge and visiting space for visitors. In Torvean, decorators were in at the time of our unannounced visit refreshing the paintwork. Hospital management could not give a date for the move as yet.

A greenspace initiative is well underway, transforming the grounds of the hospital using endowments and Scottish Natural Heritage funding.

When finished it will include a path around the main hospital building, a specialist dementia garden and a multi-purpose 'village green'-style hub where it is hoped members of the public, friends, family, and patients will interact.

Summary of recommendations

1. Managers should ensure that a personal history which encourages and facilitates communication between the individual and nursing staff is completed.

2. Managers should ensure patients' notes should clearly record discharge planning meetings, who was invited, who attended, and the outcome.

3. We recommend that the ward round recording sheet used in Morar ward is customised so that it can be used in all three wards.

4. Managers should ensure all Adults with Incapacity (Scotland) Act 2000 guardianship and power of attorney documents and recording of details are in place clearly in patients' files and consultation with proxies is recorded appropriately.

5. Managers should ensure that in all three wards activity care plans are person-centred, reflecting the individual's preferences, and patients are supported to take part in identified activities specific to their care needs.

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.

Kate Fearnley

Executive Director (Engagement & Participation)

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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