Mental Welfare Commission for Scotland

Report on announced visit to: Ravenscraig Hospital, Dunrods E & F, Inverkip Road, Greenock, PA16 9HA

Date of visit: 8 March 2016

Where we visited

Dunrods E & F are two of three wards remaining on the Ravenscraig site. The wards jointly have 30 beds, providing care for people with dementia who require continuing NHS care due to their complex needs or challenging behaviours. Currently Dunrods E has 18 patients and Dunrods F has 12. We last visited this service on 1st July 2015 and made recommendations relating to the level of activity provision, care planning and life history, staff training, access to psychology and pharmacy support, staff training and personalisation of the environment.

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

Who we met with

We met with 8 patients and 10 carers/relatives/friends.

We spoke with two of the charge nurses, the occupational therapist, one nursing assistant and a representative from the local advocacy service.

Commission visitors

Mary Hattie, nursing officer, - visit co-ordinator

Alison Goodwin, social work officer

What people told us and what we found

Care, treatment, support and participation

Multidisciplinary team input and reviews

The wards have input from two consultant psychiatrists, occupational therapy provide regular sessions and the ward has recently benefited from the provision of regular weekly pharmacy sessions. The GP attends the ward three times a week and can be called out with this if required. Physiotherapy, speech and language therapy and dietetics are all available on a referral basis. A clinical psychologist for Old Age Psychiatry has been in employment now since November 2015 and with the assistance of a nurse trained in management of stress and distress, are now rolling out training to staff.

Multidisciplinary reviews were well documented and the need for NHS continuing care was reviewed on a six monthly basis. Physical health care was also reviewed at this time.

Life histories

We had highlighted the lack of life history information during our last visit. We were therefore pleased to find life histories in the files we reviewed. These varied considerably in quality with several life histories containing a wealth of information

about the individual's family, working and social life and major life events illustrated with pictures. We were told that work on this is ongoing.

Care plans

Whilst there was information about personal preferences and hobbies contained within the life histories, we found no evidence of this being reflected within care plans.

With one exception care plans for the management of stress and distress were very generic, with no person-centred information indicating how the individual expresses their distress, known triggers or strategies for distraction or de-escalation. One care plan did have information on how the individual expressed distress and the triggers for this, however the only management strategies included were use of as required medication and restraint.

Care plans were reviewed on a regular basis and this was documented within the nursing notes.

Recommendation 1:

Managers should ensure nursing care plans are person centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

Recommendation 2:

Managers should ensure that care plans for the management of stress and distress include the known triggers or strategies for distraction and de-escalation which work for the individual.

Use of mental health and incapacity legislation

Adults with Incapacity (Scotland) Act 2000

Individuals who were assessed as lacking capacity to consent to their treatment were being treated under part 5 of the Adults with Incapacity (Scotland) Act 2000, (AWI Act). Section 47 certificates (s47) authorising treatment were on file for all the individuals whose care we looked at, however some of these had expired. This was highlighted during the visit. The hospital's admission sheet, which is where key contact information is recorded, has space for recording next of kin but makes no provision for recording whether there is a guardian or power of attorney, or their contact details.

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

Two individuals were subject to detention under the Mental Health (Care and Treatment) (Scotland) Act 2003, (The Mental Health Act). Copies of detention paperwork were held within their file. T3 forms were in place to authorise treatment.

However in both cases this did not cover all medication prescribed. This was highlighted to the responsible medical officers by the charge nurses on the day and followed up by the Mental Welfare Commission.

Where covert medication was being administered, our covert medication pathway had been completed. However some of these did not have input from a pharmacist. We are aware that regular pharmacy input to the wards has commenced recently and are advised that the covert medication pathways will be reviewed with pharmacy input.

Recommendation 3:

Responsible medical officers should ensure that, where individuals are unable to consent to their treatment, appropriate legal authority, under either the AWI Act or the Mental Health Act is in place.

Rights and restrictions

We saw several patients being nursed in specialist recliner chairs, some with pelvic positioners in place. On discussion with the charge nurse we were advised that this was due to these patients being at high risk of falls due to their unsteady gait. For those patients whose care we reviewed we found that falls risks assessments had been completed and were subject to regular review. Physiotherapy advice had been sought and there were recommendations with regard to appropriate management of falls risk, which included the use of the specialist chairs and, in some cases, pelvic positioners. There were nursing care plans for this; however we did not feel these were sufficiently detailed. There was no reference to when and for how long the patient should be nursed in the chair. However from our observations during the day, discussions with staff and from the nursing notes, it was clear that the individuals care was appropriate. Patients were supported and encouraged to mobilise throughout the day and were only restricted to the chair at times when they were at particularly high risk of falls due to tiredness and unsteady gait. We spoke to the spouse of one patient who was nursed in this way. They advised us they had been consulted and were happy with the way this was being used.

Recommendation 4:

Managers should ensure that where patients are subject to restrictions, such as the use of a reclining chair and positioning strap, there is a detailed individual care plan setting out the reasons and threshold for its use. This should include information on the maximum duration of time the individuals freedom of movement can be restricted and include the need to support the individual to mobilise on a regular basis. Alternative ways of managing the risk, if possible, should also be included.

Activity and occupation

The unit has input from occupational therapy to provide activities. There is one programmed activity session each working day; sessions include group activities such as social breakfast group, flower arranging and therapy sessions. Individual sessions include activities such as hand massage, facials and hairdressing. There are also regular musical events with visiting singers, which relatives are invited to. Nursing staff run cinema afternoons each week. A hairdresser attends the ward once a fortnight.

There is no dedicated activity co-ordinator. Throughout our visit, staff were busy attending to personal care and the clinical and nutritional needs of their patients.

TV was on in both sitting rooms, and some patients were in their bed areas with the radio playing, however there was very little evidence of patients participating in activities. On reviewing nursing notes we found that, other than the activities recorded by the occupational therapist, there was no evidence of individuals being offered or participating in activities which would provide a meaningful day.

Several of the visitors we spoke with commented on the lack of stimulation and activity in the unit. Visitors were very clear that this was not a criticism of the nursing team, who they felt were always busy but very caring and approachable.

We had made recommendations relating to the provision and recording of activity in our previous report, which have not been adequately addressed.

We were told that there is a minibus on site which the occupational therapists can use but due to the complex needs of the patients in Dunrods E & F, outings in the bus are very infrequent. However in fine weather patients are taken for walks in the grounds.

A local chaplain holds a monthly service in the ward, which is attended by patients and relatives. Members of the local St Vincent de Paul society also visit the ward regularly.

Recommendation 5:

Managers should ensure that individuals have access to a range of recreational and therapeutic activities to meet their individual needs and provide them with a meaningful day and that this is recorded.
Given our previous recommendation and the lack of action we will escalate this to senior management.

The physical environment

We were advised that planning approval has been granted for a new building adjacent to Inverclyde hospital and the Dunrod units will be relocating to this once it

is complete; however as building has not yet commenced there is no date set for this at present.

Staff advised us that maintenance issues continue to be addressed promptly. We saw that new furniture has been provided throughout the unit and work has been undertaken to make the environment more interesting, including stencils and other art work on walls, personalisation of some bed areas with pictures, flowers and other items.

One room has been turned into an onsite cinema, complete with old movie posters, and even an usherette ice-cream tray. Information on movie afternoons, which visitors can join, was posted on the ward door. We are told that this is popular with patients and visitors alike, and the cinema room is used for individual as well as group viewings.

The ward has an enclosed garden which is shared with Dunrods G ward. New garden furniture has been purchased. We were told that when the weather is fine patients can access this with the support of staff or relatives. However at the time of our visit it was not being used due to the weather conditions. We are advised that the ward has been approached by a national building society and a retailer, through their own staff volunteering schemes, offering the services of their staff for a day to help improve the garden. They hope to take this up in the near future.

Any other comments

The wards hold a monthly carers meeting, which provides a forum for visitors to meet with ward and senior staff to discuss any concerns. This enables management to keep visitors informed of any proposed changes to the service.

Several of the visitors we spoke with commented that they felt the ward was understaffed. They also expressed concern at the level of bank and agency nursing used, commenting on the importance of care being provided by regular staff that are known to, and know, the patients.

Recommendation 6:

Managers should review staffing to ensure that there is adequate resource available to meet the level of clinical activity and provide holistic care to the patients within the wards.

Training

We made a previous recommendation that staff should be trained to skilled level in the NES excellence in practice framework for dementia care and that this should include training in the management of stress and distressed behaviours.

We were pleased to hear that all nursing assistants have completed the NES training at skilled level, as have a small number of registered nurses. Training in the management of stress and distress is scheduled to commence in April.

Food

We were told by staff that there were issues with both the suitability and the quantity of food provided to the ward.

Due to the nature of their illness there are occasions when patients do not eat at mealtime, due to being to drowsy, or agitated. The ward is only allowed to order meals for 30 patients. An order of a sandwich or other snack is counted as a meal and the numbers of hot meals servings are consequently reduced. Therefore there is no provision for the ward to receive a supply of snacks such as sandwiches, yogurt or other desserts which could be kept in the fridge and given if the person is hungry out with meal times, meaning the only option available is liquid nutritional supplements.

We were also told that, although the menu purports to provide a soft textured diet some of the food supplied is unsuitable, apples are sent up as the fruit choice, and cannot be served, often the vegetables are too hard for the patients to manage and this has on occasion led to choking incidents. Steak and chicken were also reported as being too hard to chew.

Mealtimes are an important highlight of the day, providing stimulation, sensory input and the nutrition necessary to maintain physical wellbeing. However the suitable meal choices available are limited, meaning there is little variety and patients receive the same meals on a very regular basis.

Recommendation 7:

Managers should review the catering provision to ensure that the menu is adequately varied and fully meets the dietary needs of the patients, and that there is provision on the ward of a variety of sandwiches or other suitable snacks which can be given to patients out with mealtimes.

Summary of recommendations

1. Managers should ensure nursing care plans are person centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

2. Managers should ensure that care plans for the management of stress and distress include the known triggers or strategies for distraction and de-escalation which work for the individual.

3. Responsible medical officers should ensure that, where individuals are unable to consent to their treatment, appropriate legal authority, under either the AWI Act or the Mental Health Act is in place.

4. Managers should ensure that where patients are subject to restrictions, such as the use of a reclining chair and positioning strap, there is a detailed individual care plan setting out the reasons and threshold for its use, including information on the maximum duration of time the individual's freedom can be restricted and include the need to support the individual to mobilise on a regular basis. Alternative ways of managing the risk, if possible, should also be included.

5. Managers should ensure that individuals have access to a range of recreational and therapeutic activities to meet their individual needs and provide them with a meaningful day, and that this is recorded.

6. Managers should review staffing to ensure that there is adequate resource available to meet the level of clinical activity and provide holistic care to the patients within the wards.

7. Managers should review the catering provision to ensure that the menu is adequately varied and fully meets the dietary needs of the patients, and that there is provision on the ward of a variety of sandwiches and other suitable snacks which can be given to patients outwith mealtimes.

Given our previous recommendation and the lack of action we will escalate 6 to senior management.

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

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