Mental Welfare Commission for Scotland

Report on announced visit to:

Inverclyde Royal Hospital, Larkfield Unit, Ward 4 A&B, Larkfield Road, Greenock, PA16 0XN.

Date of visit: 20 June 2016

Where we visited

Ward 4 is located on the first floor of the Larkfield unit which is part of the District General Hospital. The unit has 20 beds for the assessment of older people and is designated as short stay. The ward is divided into two sub units, 4A provides 10 beds for people with dementia and 4B provides 10 beds for people with a functional illness. We last visited this service on 2 April 2014 and made recommendations relating to covert medication, life history documentation, care plans, activity recording , mental health and incapacity legislation documentation.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision and care planning.

Who we met with

We met with and/or reviewed the care and treatment of nine patients and seven carers/relatives.

We spoke with the charge nurse, occupational therapist, consultant, members of the nursing team and advocacy.

Commission visitors

Mary Hattie, Nursing Officer

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

Multidisciplinary Team Input and reviews

The ward has input from two consultants and has a GP who visits the ward Monday to Friday. Out of hours medical care is provided by the junior doctor on call rota. The psychologist sees patients on a referral basis and is providing training in managing stress and distress to the ward team. There are dedicated physiotherapy, occupational therapy and pharmacy sessions. Speech and language therapy and dietetics are provided on a referral basis and respond promptly to requests. There is regular social work input to the multidisciplinary team meetings. The consultants meet with families when required to discuss decisions regarding care. There are good links with the local advocacy service.

Life histories and Care plans

Life history information was recorded for the majority of patients whose care we looked at. However the quality of this varied considerably, and the information

gathered was not always reflected in the patients individual care plan. This issue had been the subject of a recommendation in our previous report.

Care plans are based on risk assessments and are reviewed regularly. The standard of care planning varied with some excellent examples of person-centred care planning and some care plans containing little person-centred content. Care plans for stress and distressed behaviour were not sufficiently detailed and lacked person-centred information indicating how the individual expresses their distress, known triggers or strategies for distraction or de-escalation.

Recommendation 1

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

Views of relatives and carers

All of the relatives and carers we spoke to were very positive about the care being provided and the communication with the ward team. They stated that staff were helpful, supportive and nurturing and they always felt welcome on the ward.

Use of mental health and incapacity legislation

Where 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), s47 certificates authorising treatment were on file for all the individuals whose care we looked at.

Where individuals were subject to guardianship or had a power of attorney, copies of the powers were on file and the contact details of the proxy were recorded.

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

Where individuals were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003, (MHA), copies of detention paperwork were held within their file. T2 or T3 forms were in place to authorise treatment.

Where ‘as required medication’ is prescribed there are individual protocols for its use.

Rights and restrictions

The doors to both units are secured with a keypad. We were told that there is a locked door policy and patients who are informal and able to leave the ward can ask staff to open the doors. However this information was not on display anywhere.

We noted several patients within ward 4A wearing their outdoor jackets and attempting to leave the ward. Each of these individuals was subject to detention under the MHA.

We saw several patients being nursed in specialist recliner chairs fitted 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. 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. 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.

Recommendation 2

Managers should ensure that information on how to exit the ward is available and clearly displayed.

Recommendation 3

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 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.

Activity and occupation

The ward benefits from having 30 hours of input from an occupational therapist per week. As the ward is a short stay assessment unit, much of the occupational therapist's time is focused on assessments, limiting the time available for the provision of recreational or therapeutic activity. The ward has until recently benefited from having a part time occupational therapy assistant who was able to focus on activities within both units. This post is currently vacant.

The activity timetable showed that each unit had three activity sessions, run by the occupational therapist, scheduled per week. During our visit there was a music session in 4A involving five patients and a "no bake" activity within 4B involving three patients.

On reviewing patient notes there was no evidence of patients participating in any activity provision other than the sessions referred to above, or outings with their relatives. We were told that nursing staff do undertake activities with patients and on occasion will take them out for walks where time permits, but this is done in an ad

hoc way as clinical activity allows and this was not recorded in the notes which we reviewed.

We were told that one of the nurses arranged access to a Sunday worship service via the internet when they were on duty on a Sunday.

We had previously made a recommendation relating to recording of activity provision.

Recommendation 4

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.

The physical environment

The ward is clean and bright with dementia friendly signage throughout. Ward 4A has one large dining/day area which is subdivided by partition walls to create smaller more domestic scale areas; however it remains effectively one room, which can be noisy at times. There is a small sitting area in the corridor, which was used throughout the visit.

Ward 4B benefits from having separate sitting and dining facilities and a quiet sitting room. We noted that a number of wheelchairs were being stored within the sitting area.

The ward has two disabled access shower rooms, these are well designed, however we were advised that ventilation is poor. There is a large disabled bathroom; we noted that this area was also being used to store hoists. The charge nurse advised us that there was a lack of storage facilities within the ward.

As the ward is on the first floor there is no direct access to outdoor space. There is a secure garden however, access to this is from the corridor downstairs. We were advised that visitors can and do use the garden during visits and where staff are able to they will take patients into the garden. Due to clinical workload, and staff having to be off the ward to access the garden, this is not happening regularly.

Any other comments

Of the nine patients whose care we reviewed three had commenced their stay in another hospital due to there being no bed available within ward 4. We were advised by staff that, due to availability of beds and difficulties with finding suitable placements for patients who are fit for discharge or transfer to a long stay environment, this is a not an infrequent occurrence. At the time of our visit we were told that five patients were awaiting transfer to long term NHS beds or nursing home care.

The charge nurse and one other member of nursing staff raised the issue of catering. We were advised that, whilst the ward was represented on the catering subgroup, which reviewed and set menus, they told us that the meals provided on a day to day basis were often not adequate to meet their patients dietary needs.

We were told that there was provision for the ward to order snacks and supplements. However the provisions sent were often less than that which had been ordered, resulting in not having adequate snacks to meet patients' needs. We raised this issue with the senior nurse manager who advised that she had not been made aware of staff concerns prior to our visit. She has asked staff to keep a note of discrepancies between what is ordered and what is provided and will review this.

Recommendation 5

Managers should review the catering provision to ensure that the meal and snack provision is adequate to fully meet the dietary needs of the patients.

Summary of recommendations

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

2. Managers should ensure that information on how to exit the ward is available and clearly displayed.

3. 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 individuals 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.

4. 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.

5. Managers should review the catering provision to ensure that the meal and snack provision is adequate to fully me the dietary needs of the patients.

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.

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