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Mental Welfare Commission for Scotland

Report on announced visit to: Mid Argyll Community Hospital and Integrated Care Centre, Knapdale Ward, Blarbuie Road, Lochgilphead, PA31 8JZ

Date of visit: 10 May 2016

Where we visited

Knapdale Ward is a 12-bedded, mixed sex dementia ward in Mid Argyll Hospital.

We last visited this service on 6 August 2014. At that point there were two dementia wards within Mid Argyll Hospital, with the second ward designated as a continuing care unit. In 2015, NHS Highland took the decision that all the dementia beds in the Mid Argyll Hospital were not needed and the continuing care unit was closed. Several patients in the continuing care unit were able to move into care home settings. Currently, of the 12 beds in Knapdale, eight are designated as assessment beds and four are beds for people who currently need continuing in-patient care.

When we last visited the two wards in 2014, we made one recommendation: about recording information when a welfare proxy, either a guardian or attorney, is in place.

On the day of this visit we wanted to look generally at how care and treatment was being provided in Knapdale ward, following the amalgamation of the two wards in the hospital.

Who we met with

We met with four patients and reviewed their case notes and the notes for four other patients.

We spoke with the ward manager and several members of the nursing team and also met the clinical services manager.

Commission visitors

Ian Cairns, social work officer and visit coordinator

Douglas Seath, nursing officer

What people told us and what we found

Care, treatment, support and participation

We met four patients we were able to have a conversation with and they were all satisfied with their care and treatment in the ward. One person, who wanted to go home, knew he was in hospital and he knew that his needs were different from many of the other people on the ward, whose dementia was more advanced. Even though he was clear that he wanted to be at home he clearly said that he felt he had a good relationship with staff and that they were treating him well.

Care plans

New care planning documentation has been introduced in the ward and there was evidence of good, person centred plans in the files we reviewed. Care plans were backed by appropriate risk management plans and had specific details in them which made it clear that the care plans were individualised and were based on each person’s particular needs. Each individual care plan also had some element of summative evaluation recorded in the daily record, with the purpose of monitoring over a period of time if specific interventions continue to be relevant or are not needed, in which case the individual care plan is changed or discontinued. We saw clear evidence in files that this is happening. We saw evidence of how staff are encouraging patients to mobilise as independently as possible and how this is reflected in care plans and risk assessments. We also spoke to several staff about the process of introducing the new care planning documentation and we were told that staff felt they became familiar with the new documentation very quickly and found it easy to work with.

Physical health care

We were told on the day there are good links between the dementia ward and the general medical ward in Mid Argyll Hospital, and the ward manager has been keen to encourage healthcare assistants to do some shifts in the medical ward. We also heard that there is good input into the dementia ward from allied health professionals, such as physiotherapists and dieticians, most of whom are also based in the hospital.

The clinical input for some people in the ward is managed by a consultant psychiatrist, while for other patients it is managed by GPs. This does create some issues about medical input from doctors in training posts, but from the evidence we saw in files this does not compromise the physical healthcare provided to patients in the ward. There seems to be good input in relation to all physical healthcare needs and we saw one clear example of this in one patients file. This person had collapsed in the ward on the previous weekend and there had been good and prompt medical input, and very thorough follow up with an extremely detailed record completed by the trainee doctor.

Participation

Most of the patients in the ward had dementia which had progressed to a stage where verbal communication was very limited. We saw evidence in files though of staff gathering information to try to encourage as much participation as possible. We saw ‘Getting to know me’ forms with detailed information and a form called ‘Five must do’s with me’ which records information for each individual patients about what matters to them, who matters to them, what information they need, how they can be involved and how staff can personalise care. We also saw good evidence in files of relatives, guardians and attorneys being involved in decisions about care and treatment. It was clear that staff are collecting background information from relatives and welfare proxy’s on a consistent basis and are talking to relatives to clarify the reasons for admission on a routine basis. In ‘do not attempt cardiopulmonary resuscitation' (DNACPR) forms, we also saw relatives being consulted and also being involved in reviews.

Use of mental health and incapacity legislation

We reviewed medical prescriptions for all patients in the ward. We were pleased to see that very little medication was prescribed to be administered on an 'as required' basis for agitation. There were no issues relating to treatment requirements where patients were detained under the Mental Health Act, with appropriate authorisation in place.

When treatment needed to be authorised under the Adults with Incapacity Act, s47 certificates, certificates which are completed by a doctor prescribing treatment, were in place.

Staff are now clarifying on a consistent basis when someone is admitted to the ward, if a guardian has been appointed or if powers of attorney have been granted. In some cases where a welfare proxy was noted as being in place, staff had not been able to get a copy of the specific order. This is something which staff will normally rely on relatives providing them with and we would suggest that staff may need to remind the guardian or attorney that the ward would want to keep a copy of the order in the individual patient's file.

Activity and occupation

There are four or five sessions provided by the occupational therapy service in the ward each week. The occupational therapist (OT) generally focuses on completing individual assessments with patients, while the OT assistant arranges activity provision. Ward staff also provide activities within the ward and we saw evidence of activity provision recorded in individual files.

The physical environment

The ward was clean and bright on the day we visited and there was a quiet, calm atmosphere during all the time we spent there. There is an easily accessible garden area which is entered out of the lounge/conservatory area in the ward.

It was warm and sunny when we visited, and one issue about the physical environment which was evident was that it can get very hot in the lounge/conservatory because none of the windows open. We would suggest that the service manager looks at how the lounge/conservatory can be kept cool and comfortable in hot weather.

Any other comments

We were told on our visit that representatives from the Royal College of Psychiatry (RCP) were also visiting Lochgilphead Hospital as part of a review of the model of provision for dementia care which the RCP had been asked to undertake by NHS Highland. The Commission would be interested to know the outcome of this external review.

Summary of recommendations

There are no recommendations following this visit.

Good practice

As mentioned above, new care planning documentation is being used in the ward. Care plans are being well evaluated, with comments on each individual plan included in daily progress notes, regular summative reviews and with care plans being amended or discontinued as appropriate.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Kate Fearnley

Executive director (engagement and 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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