Mental Welfare Commission for Scotland

Report on announced visit to: Cleland Hospital, Parkside North & Parkside South, Bellside Road, Cleland, ML1 5NR

Date of visit: 23 May 2016

Where we visited

Parkside North is a 15 bedded all male ward and Parkside South is a 15 bedded all female ward. The bedrooms are single with ensuite facilities. The age range of the patient group is from mid 50s to mid 80s. Most of the patients have spent the majority of their adult life in care settings and are institutionalised. For many, attempts to offer care within the community or residential homes have been unsuccessful.

The wards are moving towards a rehabilitation delivery of care. This will allow future admissions to have a focus on moving towards community discharge. With this change in mind the units have had an assessment kitchen installed for patient use and to allow occupational therapy assessments to take place on site.

We last visited this service on 20 February 2015 and made recommendations around the recording of activity participation, care plan interventions and the need to update medication recording system.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the environment as there have been changes made since our last visit.

Who we met with

We met with nine patients and one relative.

We spoke with the charge nurses, the activity coordinator and a few of the nursing staff.

Commission visitors

Margo Fyfe, nursing officer and visit coordinator

Mike Diamond, executive director (social work)

David Barclay, nursing officer

What people told us and what we found

Care, treatment, support and participation

The wards have multidisciplinary teams. This comprises medical staff, nursing staff, an occupational therapist between both wards, an activity coordinator between the wards, a psychologist one session per week in each ward and a housekeeper and domestic staff. We heard that there is no pharmacy input directly to the hospital and no pharmacy audits are carried out. We are of the view that it is good practice to have regular pharmacy audits and would recommend managers consider reviewing this issue.

Care Plans

The service has moved to the electronic record system MIDIS. As in other areas across the health board that use the system we found it to be slow. Staff commented that it can take up more time to record in patient files than in the past which in turn can take them away from direct patient contact. We found the recording of multidisciplinary reviews on MIDIS to be inconsistent and lacking detail

The care plans viewed were person centred and had a clear mental health focus. Although reviews were evident there would be benefit in having more detail in regard to interventions carried out and any changes made to move towards achieving the care goals. A regular audit system would help to ensure this area is consistently completed for all patients.

Do not attempt cardiopulmonary resuscitation (DNACPR) documentation

It was good to see that DNACPR forms that were in place were also on a separate list to ensure these were reviewed when necessary.

Recommendation 1

Managers should review pharmacy input and audit within the units.

Recommendation 2

Managers should ensure all staff are aware of how to complete multidisciplinary reviews on the MIDIS system and that these are done accurately reflecting attendance and decisions made at the meetings.

Recommendation 3

Managers should ensure care plans are regularly audited and that interventions and reviews accurately reflect the care provided to individuals.

Use of mental health and incapacity legislation

We found consent to treatment documentation under the Adults with Incapacity (Scotland) Act 2000 (the Adults with Incapacity Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) to be in place. However not all Adults with Incapacity Act certificates covered all areas of care and treatment for the individuals. We discussed this on the day of the visit and recommend that these certificates, where in place, should be reviewed.

Only one female patient was detained at the time of our visit and all Mental Health Act documentation was in place. We were pleased to see the use of a front sheet to this documentation that detailed the type of detention in place along with dates for renewal and any relevant additional safeguards such as consent to treatment certificate dates and specified person dates.

Recommendation 4

Medical staff should review Adults with Incapacity Act consent to treatment certificates and treatment plans to ensure they accurately cover all appropriate care and treatment for the individuals concerned.

Rights and restrictions

The main doors to the units are keycard entry. We were informed this is for general safety to ensure staff are aware of who is coming into the units. Both units have access to garden areas that are well set out and pleasant places to sit and look over surrounding countryside.

Activity and occupation

There is an activity co-ordinator in place who divides her time between the two units. She organises group activities with the assistance of nursing staff as well as carrying out one to one activities. We were pleased to see that activity participation is recorded in a separate folder if the activity was lead by the activity co-ordinator. All other activity participation is detailed in the MIDIS continuation notes written by nursing staff. We suggested that it would also be helpful to note when patients have been offered but refuse to participate in activities.

The variety of activities on offer varies from pamper sessions to games in the units and regular outings in the local area and further afield in the dedicated transport. Patients met with spoke highly of the activity provision and felt that activities and outings were centred around what the patients enjoyed.

We heard that there are plans to use the new shared group space for social events that patients from both wards can attend. We look forward to hearing how the use of this space has progressed at future visits.

The physical environment

Since the last Commission visit to the units there has been an extension built on to the unit which houses an assessment kitchen and shared group activity space. We heard about the benefit to the patients of having an activity space off of the wards and of plans to utilise this for joint ward activities. We also heard that now the occupational therapist is able to carry out full kitchen assessments with patients as the ward moves towards a rehabilitation care focus. We heard that it is hoped that future admissions will come with a rehabilitation focus of discharge to the community and as such that this new kitchen facility will be used in the full rehabilitation process. We look forward to hearing how this progresses at future visits.

It was good to see the attention to detail in the new front garden area. Living sculptures capture the history of the surrounding area. We were pleased to note the

intention for patients to participate in the development of a vegetable garden and to see raised beds for planting that those less physically able can use.

Inside the units we found good attention to personalisation of bedrooms. It was good to hear that patients are encouraged to pick their own colour scenes, wall hangings and bedclothes. The lounge areas were bright and homely.

We noted that there are no smokers in the female ward and that the male ward are moving towards becoming a smoke free environment. We heard that smoking cessation is available to all patients should it be desired.

Any other comments

The patients we met with were complimentary of staff input to their care as was the relative who spoke to us.

Staff had a good knowledge of the patient group and we noted caring interactions between staff and patients during our visit.

Summary of recommendations

1. Managers should review pharmacy input and audit within the units.
2. Managers should ensure all staff are aware of how to complete multidisciplinary reviews on the MIDIS system and that these are done accurately reflecting decisions made at the meetings.
3. Managers should ensure care plans are regularly audited and that interventions and reviews accurately reflect the care provided to individuals.
4. Medical staff should review Adults with Incapacity Act consent to treatment certificates and treatment plans to ensure they accurately cover all appropriate care and treatment for the individuals concerned.

Good practice

We were please to see the use of an information sheet at the front of legal documentation detailing the type of detention and all relevant review dates.

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.

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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