Mental Welfare Commission for Scotland

Report on announced visit to: Torvean Ward, Old Age Psychiatry, New Craigs Hospital, 6-16 Leachkin Road, Inverness, IV3 8NP

Date of visit: 8 October 2019

Where we visited

Torvean Ward is a 12-bedded complex care ward for people with dementia based in the New Craigs hospital site. Most patients on this ward have been admitted from general hospital wards and from care homes following a breakdown of placement. Patients can exhibit stressed and distressed behaviours and discharge to care home and other settings requires careful planning.

We last visited this ward on 31 January 2018 and made one recommendation in relation to the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

On the day of this announced visit we wanted to meet with patients, speak to staff, and follow up on the previous recommendation. On the day we visited, the ward was fully occupied.

Who we met with

We met with and/or reviewed the care and treatment of six patients. An advocacy worker was present for two of these meetings. In addition to speaking with nursing and healthcare staff we met with the clinical area manager and interim service manager for older adults' mental health services and discussed our findings with them at the end of the visit.

Commission visitors

Moira Healy, Social Work Officer

Susan Tait, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patients who were able to talk to us told us about their care, and were positive about the support from staff.

At the time of the visit the ward was busy and quite noisy due to clinical activity and this appeared to disturb some patients.

Multidisciplinary team

On the day of the visit the multi-disciplinary team (MDT) consisted primarily of nursing and medical staff. Weekly ward rounds were recorded within contemporary use clinical notes but they were not always easy to find. There are five consultant psychiatrists who attend to patients on the ward and this is likely contributing to different approaches to recording.

MDT review sheets were easier to locate as they were written on a different coloured sheet of paper however these are carried out either when required or on a three/six monthly basis. Due to the different practices of the five different consultants and the variability of recording of ward rounds and MDTs, we think this should be addressed.

Recommendation 1:
Managers should audit MDT paperwork and take steps to ensure that care records are completed consistently.

Allied Health Professionals

We were advised that this ward shares 0.6 whole time equivalent of an occupational therapist (OT) and 0.4 of an OT technician between two other wards. Input from the OT is focussed on those patients preparing for discharge. The OT technician post is currently vacant and there is no activity coordinator. This provision seems inadequate for the number of patients with such complex support needs.

On the day of the visit there were no organised activities in the morning and one nurse led activity in the afternoon. There was no scheduled activity programme on a group or individual basis and we found this disappointing.

Pharmacy input is from a pharmacy technician who checks on medication and compliance with part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') on a monthly basis. A pharmacist is involved if there are any covert medication prescriptions and is available for consultation on request. Speech and language therapist is arranged on a referral.

Input from psychology services is 3.5 hours per week. The psychologist supports staff training and support in using the Newcastle model when working with patients who exhibit stressed and distressed behaviour.

Attempts were being made to increase the knowledge of staff when caring for patients with this high level of complexity but this was in the early stages of development.

There is currently no dedicated time from a physiotherapist but a physiotherapist based in another service within the hospital will respond to specific referrals. There is no art, music or other input from external sources.

Recommendation 2:
Managers should review the current provision of therapeutic and recreational activity with a view to increasing the range of activity available for all patients.

Documentation

Care plans were variable in quality. Physical healthcare plans were generally detailed but care plans in relation to mental health often lacked personalisation and meaningful details. Reviews were also variable in quality; some provided a good level of detail, were personalised and were reviewed regularly. However, this was inconsistent.

The Commission has published a good practice guide on care plans.

It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

When 'Getting to Know Me' forms were completed they gave valuable information in relation to the patient's personal history.

Recommendation 3:
Managers should audit care plans in relation to mental health and take action to ensure they are person centred and describe the specific interventions required for the individual patient.

Use of mental health and incapacity legislation

On the day of the visit six patients were detained under the Mental Health Act. Where medical treatment is being given without consent beyond a two month period, a certificate (T3) is required and these were unavailable for two patients who required them to be in place. These had been completed but were filed in historical notes and difficult to find.

We consider it good practice that current certificates are kept with the drug prescription sheet.

Where an individual lacks capacity in relation to decisions in relation to medical treatment under Section 47 of the AWI Act, an s47 certificate must be completed by a doctor. We found certificates were in the files where required and individualised treatment plans were accompanying them in the prescription sheets.

We found all documentation for patients who had a welfare proxy under the AWI Act (either a welfare guardian or power of attorney) were in the file and easy to locate.

Recommendation 4:
Managers should ensure that copies of consent to treatment certificates are located beside the drug prescription sheets.

Rights and restrictions treatments

Advocacy support is available and an advocacy worker supported patients to meet with us on the day of the visit.

The door to the ward was locked for egress. There is locked door policy in place to support this decision.

The Commission has developed *Rights in Mind*.

This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

This can be found at https://www.mwcscot.org.uk/rights-in-mind/

Physical environment

Staff in the ward talked to us about the difficulties delivering high quality care in the current physical environment.

The entrance to the ward is via a locked door onto a foyer area which is shared with another ward, offices and toilets and this is not a welcoming introduction to the ward. It is possible to access the ward via other doors however there is no welcome sign or member of staff to welcome a visitor onto the ward.

The ward is set out along two long corridors and looked clinical with no artwork. The handrails, which are there to support people with a dementia and limited mobility, offer no marked contrast, making it difficult for some patients to recognise them as aids to support independent and safer mobility.

The lounge area has furniture which is all the same height and is not appropriate to this group of people who need a variety of seating to aid independence.

There are four single bedrooms with toilet and en suite showers, four single rooms with en suite toilet and wash hand basin, and four single rooms with a sink only and patients in these rooms use toilet and bathroom facilities on the corridor.

The bedrooms were pleasant but we did not see evidence of personalisation. Two patients we met with, and whose notes we reviewed, had money to spend on items to personalise their rooms (e.g. buying their own chairs, soft furniture) and purchase activity equipment specific to them. There had been no attention given to see how their funds could be give a more person centred space or enhance their individual activities. This was raised with the manager on the day of the visit.

The ward is a distance away from the main hospital site and the other two old age wards. Access to the main building is up a steep road which many of the patients on the ward would find difficult to access if walking. We were told some patients are taken to the hospital café in a wheelchair when staffing provision allows this.

There is a pleasant garden but the general physical environment appeared in need of attention and not suited to this group of patients.

Recommendation 5:
Managers should ensure that a dementia environment assessment be undertaken and the findings from this implemented.

Recommendation 6:
Managers should ensure that the ward environment is welcoming and fit for purpose.

Summary of recommendations

1. Managers should audit MDT paperwork and take steps to ensure that care records are completed consistently.

2. Managers should review the current provision of therapeutic and recreational activity with a view to increasing the range of activity available for all patients.

3. Managers should audit care plans in relation to mental health and take action to ensure they are person centred and describe the specific interventions required for the individual patient.

4. Managers should ensure that copies of consent to treatment certificates are located beside the drug prescription sheets.

5. Managers should ensure that a dementia environment assessment be undertaken and the findings from this implemented.

6. Managers should ensure that the ward environment is welcoming and fit for purpose.

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