**Mental Welfare Commission for Scotland**

**Report on announced local visit to:** Glenlee Ward, Midlothian Community Hospital, 70 Eskbank Road, Bonnyrigg, EH22 3ND

**Date of visit:** 8 December 2015

**Date sent to service:** 19 January 2016

## Where we visited

Glenlee Ward is a 20 bedded continuing care ward for patients who are over 65. All patients on the ward have a mental health problem most of whom have dementia; and can exhibit stressed and distressed behaviour. We last visited the ward in November 2014 and chose to follow up on a number of concerns that had been identified on our previous visit as requiring action. These were in relation to: care plans, documentation in relation to The Adults with Incapacity (Scotland) Act 2000(the Adults with Incapacity Act), activities and the environment.

On the day of this visit, which the service had been notified of in advance, there were 19 patients. Four patients were subject to detention under the Mental Health (Care & Treatment)(Scotland) Act 2003 (the Mental Health Act) and there were four people whose discharge had been delayed. There was one person on constant observations. For each of the four people who had been identified as ready for discharge, a nursing home had been identified and these people were awaiting a local authority funded place. All four people had been identified as ready for discharge within the last two to three weeks.

Glenlee ward has a large living room/dining area which is situated near the front entrance to the ward. It is divided into two distinct areas for these purposes. Just off the living/dining area there is a reminiscence room which is appropriately equipped and decorated with 1950's decor. A number of resources including books and pictures full of local photographs and national significant events are visible and can be used for individual work with patients and by their families as a way of stimulating discussion. There is also an activity room, this was welcoming and well equipped. Both rooms were in use throughout the day. Since the last visit there has been a reduction in patient numbers from 24 to 20 but staffing levels had remained the same. Two of the vacated rooms are now used as a music room which is in regular use and a Snoozelen room which has various lights and projections.

All rooms described above are unlocked and can be used by patients and visitors who may wish to take their family member or friend into a different space or a quieter area.

## Who we met with

On the day of the visit we met with eight patients and four relatives.

The day before the visit we had a telephone conversation with one relative. We also spoke to the ward manager, staff nurses, healthcare assistants, consultants, the activity coordinator, occupational therapist (OT) and OT technician on the day of the visit.

## Commission visitors

Moira Healy, Social Work Officer and visit coordinator

Margo Fyfe, Nursing Officer

## What people told us and what we found

### Care, treatment, support and participation

On the day of the visit the ward seemed well organised. Most patients were up by mid morning unless there was a specific reason for them not to be and there are clearly defined staff roles regarding morning routines which we were told has significantly improved the morning routine on the ward. We also saw evidence of warm and nurturing input from nursing and healthcare staff towards patients throughout the day.

We were told by relatives and staff that in the past year three members of nursing staff had retired and a further 5 left post - these vacancies have been filled intermittingly by bank staff (wherever possible these were staff who worked within the ward to minimise disruption for patients). Four newly appointed nurses are scheduled to start in these permanent posts in the new year.

#### Multidisciplinary team (MDT) input

There are two consultants who have clear responsibility for either the 16 Midlothian or four East Lothian patients. They visit the ward on a regular basis to see their patients, speak to staff and provide medical care for their patients.

We were informed that access to psychology is on a referral basis. However, the clinical psychologist from East and Midlothian Psychological Assessment team (EMPAT) has been involved in a two day training programme on the management of people with stressed and distressed behaviour. We were told that six members of nursing staff had already completed this training and it had been highly valued. We were informed this is to be made available for all staff on the ward and we will check on the progress of this training at the next visit.

Access to speech and language therapy is on a referral basis and we were told that referrals are addressed quickly.

#### Care plans

We took the opportunity to look at care plans, daily progress notes, weekly ward round notes and MDT review notes. Notes were held in paper files and were well organised and easy to navigate. Some care plans were person centred, had clear goals and named specific interventions which related to that individual. Within these care plans there were clear and meaningful evaluations. Whilst there has been a significant improvement in care plans within the last year, this was not consistent in all of the care plans we reviewed. One patient we met who did not have dementia

had one care plan in relation to her mental health and we felt this could have been expanded to cover several areas of her care.

The quality of the weekly ward round reviews often lacked detail and did not describe the patients needs and strengths or evaluate care given that week.

**Involvement of families**

Whilst speaking with relatives we were made aware that they were involved in decision making and were invited to MDT meetings which we were told were held once every two months. Unfortunately, we found no evidence of MDT recording and little written evidence of family involvement and yet they are clearly involved. This needs to be addressed. One relative we spoke to whilst full of praise of the care his relative was receiving on the ward said they sometimes struggled with knowing which member of staff to approach just for an update on their relative. In our view this issue requires to be addressed. Named nurses are attached to each individual patient and the ward manager was unaware of this confusion. He agreed about the importance of the named nurse introducing themselves to the relatives when a patient is admitted. A photo gallery of staff including their designation, is situated on the wall just at the entrance to the ward and is there to make this communication easier for relatives

The introduction of a care file situated just outside the bedroom of the individual was considered to be a really valuable means of communication by three family members we spoke to who read them. The ones we reviewed were up to date. Unfortunately one family member told us that his relative's care file was not always up to date. As this is such a valued aspect of communication between staff and relatives, keeping the care files up to date should be monitored by senior ward staff.

**Recommendation 1:**

Ward manager should conduct an audit of all care plans to ensure that they are person centred, individualised and describe specific interventions in relation to management of stressed and distressed behaviour. Language used should reflect these interventions as being appropriate for somebody who is distressed.

**Recommendation 2:**

Ward round notes and MDT meetings should be recorded appropriately and contain more detail.

## Use of mental health and incapacity legislation

Legal documentation in relation to the Mental Health Act was in place in the files of those patients who were detained.

Documentation in relation to powers of attorney and welfare guardianship Adults with Incapacity Act was also in place however there was no evidence of discussion of

delegation of these powers. This is important and the checklist from the Commission guidance 'Working with the Adults with Incapacity Act' could be used for this

Under the Adults with Incapacity Act, those patients who lack the capacity to consent to their medical treatment should have s47 certificates and treatment plans. These were in place in all files where this was necessary. However, doctors should ensure that where there is a welfare guardian or power of attorney these proxies should be consulted with regard to medication. Some treatment plans were not individualised. In our view this should be addressed.

Covert medication pathways were in place however there was no evidence of discussion with the pharmacist in compiling these pathways. We are aware this happens but this needs to be recorded. We will look for progress in this area at future visits.

**Recommendation 3:**

There should be an audit of all Section 47 certificates and treatment plans to ensure they are individualised. There should also be clear evidence that proxies have been included in discussions where they have powers in relation to consent to medical treatment.

## Activity and occupation

At the time of our last visit we were concerned about the lack of meaningful, purposeful and individualised activities for patients. We were told on that visit that a newly appointed activities coordinator had just started in post. We were delighted to see the significant impact that this post had with regard to the activities on the ward. There were detailed life histories in every file we reviewed. Assessments, activity plans, provision and recording of activities in all files was personalised and of a very high standard. For some individuals who have advanced dementia the activities they can participate in may be limited but there was clear evidence that everything had been done to try and involve them in some activity that they can enjoy. The use of music in particular Playlist for Life was evident in a number of files. This seems to have had a significant impact for a number of people with regard to management of distressed behaviour particularly in relation to personal care.

We spoke with the activities coordinator and she felt that the support she has had from the ward manager, staff nurse, OT technician and the OT had made a significant difference to the promotion of activities on the ward. Her involvement and the encouragement for nurses and healthcare assistants to become involved in participating in activities was quite inspiring. For example, there were boxes in the lounge which had items that patients could touch and feel. Included in those boxes were laminated, typed sheets from the activities coordinator with examples of questions that could be used to stimulate discussion about the items in the box. There was an activity board on display with all the events taking place for the week

and also a description as to why activities and engagement in activities was important for the patients on the ward. Patients we spoke with were not able to comment on the activities but we could clearly see these resources were being used throughout the day.

## The physical environment

There had been significant changes to the environment since the last visit when we described the environment as 'noisy, clinical and stark'. The configuration of the main room had changed and noise absorbing canvases on the walls, felt pads at the bottom of the chairs and tables, the TV being used only when requested to by individuals and the use of soft furnishings made a significant improvement to the ward environment. Room dividers with interesting articles which stimulated conversation also helped divide the space into two separate areas. The lounge is now situated directly beside the garden with lovely views and plenty of natural light.

Signage was also significantly improved. Toilets and bathrooms were well signposted and dementia friendly.

Glass panels at the end of each ward (which in the last visit we noted attracted the attention of one man in particular, who kept trying to leave the ward and trying to open the doors) were now covered in non transparent glass making this less confusing for patients. We saw no evidence of anybody trying to exit the ward or becoming distressed as a result of these panels being there.

There was also a significant improvement in lighting. We found corridors bright and easier to navigate for a person with dementia. The garden area is safe, well designed and enclosed and is now accessible as an interesting place to look out onto by those residents who do not wish to go out. We were told that one patient in particular had used the garden throughout the summer.

## Summary of recommendations

1. Ward manager should conduct an audit of all care plans to ensure that they are person centred, individualised and describe specific interventions in relation to management of stressed and distressed behaviour. Language used should reflect these interventions as being appropriate for somebody who is distressed.
2. Weekly ward round sheets and MDT documentation should be filled in appropriately and contain more detail.
3. There should be an audit of all s47 certificates and treatment plans to ensure they are individualised. There should also be clear evidence that proxies have been included in discussions where they have powers in relation to consent to medical treatment.

## Good practice

The area of good practice we wished to highlight and we think should be shared across NHS Lothian is the model used on Glenlea to promote activities within the ward. The activity programme is clearly meaningful, highly individualised and stimulating for patients on the ward. The programme involves all patients and relatives too if they wish to participate.

## 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)

19 January 2015

## 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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