Mental Welfare Commission for Scotland

Report on announced visit to: Arran Ward, Dykebar Hospital, Grahamston Road, Paisley, PA2 7DE

Date of visit: 7 March 2024

Where we visited

Arran ward is a 20-bedded unit in Dykebar Hospital that provides mental health rehabilitation and recovery for individuals across the Renfrewshire area.

On the day of our visit, there were 20 people on the ward and no vacant beds.

The ward provides care to males and females. It has eight single rooms in the rehabilitation service and 12 beds set out in dormitories and single rooms in the recovery service. On the day of our visit, the age of individuals ranged between 22 and 72 years old, with some receiving care and treatment in relation to their physical health as well as mental health needs. Some individuals were receiving short-term rehabilitation with their admission time expected to be two years or less, while others in the recovery service have been in the service for up to 10 years. We heard from staff how the length of admission is based on individual need, with people moving between the rehabilitation and recovery services.

We last visited this service in May 2022 on an unannounced visit and made recommendations on appropriate use of do not attempt cardiopulmonary resuscitation (DNACPR), consent to medical treatment, use of advance statements and the provision of single rooms for all individuals. The response we received from the service was that recommendations made in relation to DNACPR and consent to medical treatment were being addressed via audit and improved recording. We were advised the service introduced 'check' systems to prompt conversations regarding advance statements. We were also informed that NHS Greater Glasgow and Clyde (NHS GGC) will review mental health rehabilitation services as part of the Mental Health Strategy 2017-2027 implementation, which will include consideration to the provision of single rooms.

On the day of this visit, we wanted to follow up on the previous recommendations and look at other issues that may have had an impact on care and treatment, including discharge processes and the participation of individuals, their families and/or carers.

Who we met with

We met with, and reviewed the care of seven people and reviewed the care notes of one individual. We also met with one relative.

We spoke with the service manager (SM), the senior charge nurse, (SCN), charge nurse (CN), the consultant psychiatrist (CP), a student nurse (SN), and the occupational therapy (OT) team.

Commission visitors

Gemma Maguire, social work practitioner

Kathleen Taylor, engagement and participation officer (carers)

Claire Lamza, executive director (nursing)

What people told us and what we found

We heard from several individuals we spoke with that staff were 'great' and 'helpful' and how many 'preferred' being in Arran Ward compared to mental health admission services. We observed warm and caring interactions throughout our visit. During this visit we found a good standard of recovery-focused care being delivered to individuals with varying and complex needs.

One relative we met with told us how staff were approachable and caring but felt their family member, who was an older adult, required a more 'age-appropriate' service. The Commission recognises the benefit of specialised services in providing support to people who share similar interests and lived experiences. We discussed this issue with the SCN and SM on the day of our visit and were advised the service offers person-centred and individualised care regardless of age. We were informed that the admission criteria is under review, with consideration being given to lowering the admission age limit to 65 years old. We look forward to seeing how this progresses at our next visit.

We observed excellent person-centred care being delivered for individuals who have complex physical health conditions in addition to mental disorder. We noted this was particularly important for an individual being provided with end-of-life care, where partnership working with palliative care services has ensured the person's dignity is maintained, whilst providing personalised care and comfort within a familiar environment.

We were pleased to hear that five individuals are progressing in their discharge from hospital and found discharge care plans to be person-centred with the involvement of the individual, family and/or carer, OT, housing services, social work, and/or community-based supports.

Since we last visited, we are pleased to hear the service now has direct links with social work via the 'discharge co-ordination' team. We heard from the individuals and staff that we met with how this has helped progress assessment of support needs. We met with one individual who has been in the service since 2013 and heard how staff are advocating for the provision of 'bespoke supported accommodation'. We are pleased to hear discharge planning for this individual has been escalated by hospital managers via 'priority meetings' attended alongside Renfrewshire Health and Social Care Partnership. The Commission will continue to follow up in regard to this individual.

Some people we met with told us the availability of activities on Arran Ward was 'good', however felt 'bored' at weekends and in the evenings. We also heard concerns from a relative regarding the use of dormitories and how they feel their loved one required the privacy of a single room. On discussing this issue with staff, we heard how dormitories may benefit some individuals by reducing feelings of 'isolation'.

Care, treatment, support and participation

Care records

We found that person centred-care plans were regularly reviewed and linked well to multidisciplinary team (MDT) meetings. We found excellent recovery focused care plan evaluations relating to physical, financial, and mental health needs. We were also pleased to

note that the views of individuals, their carers and/or families were fully considered and recorded in care plans. Several individuals we met with had a detailed understanding of goals and reported regular one-to-one time with nursing and OT staff.

Care plans were stored in paper files and whilst we found up-to-date plans, these were often filed behind older care plans containing out-of-date information. We discussed this with the SCN on the day of the visit and provided advice on ensuring the most up-to-date care plan is placed at the front of files to prevent confusion. We found some nursing interventions, such as those subject to continuous intervention, to be less consistent in the quality and standard of recording. On discussing this with staff we were advised the service will be 'rolling out' a new electronic care plan template. We heard how this will help ensure all interventions are individualised, as well as improve quality of recording and security of documents. We look forward to seeing progress in this area on our next visit.

During previous visits to Arran Ward, we reported concerns in relation to staff awareness of do not attempt cardiopulmonary resuscitation (DNACPR) policy. The Scottish Government produced a revised policy on DNACPR in 2016.

This makes it clear that where an adult cannot consent and where there is a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about cardiopulmonary resuscitation (CPR), it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

On this visit, we are pleased to find that where an individual had a DNACPR decision in place, this was clearly recorded. In addition, we found that where an individual was unable to consent to DNACPR decisions, appropriate consultation had taking place with welfare guardians, power of attorneys (POA) or family members. We noted the service now carries out auditing of DNACPR decisions, including recording when review dates are due on the nursing notice board. We found some review dates on the notice board to be inaccurate and brought this to the attention of the SCN on the day of the visit who advised the information would be updated accordingly.

Risk assessments were held on the electronic recording system, EMIS. We were advised, in line with service policy, that risk assessment documents were updated when there was a change for an individual, such as increased level of risk. During our visit, we heard how the service was planning to record risk assessment discussions in the MDT meeting, even when there had been no change. The Commission agreed this would demonstrate that reviews had taken place and look forward to hearing what progress has been made on our next visit.

Multidisciplinary team (MDT)

Arran Ward has twice-weekly MDT meetings consisting of nursing staff, the consultant psychiatrist, the OT, pharmacy, junior doctors, and psychology. We were pleased to hear individuals felt involved in meetings, with their views being consistently recorded. Family members were regularly invited, with their views recorded in the meeting record.

We heard from individuals and staff that support from the discharge co-ordination team, including social work, has helped recovery and discharge plans to progress. We were also pleased to hear that links with community services, including housing and community mental health teams has helped to support the recovery of individuals after discharge.

Use of mental health and incapacity legislation

On the day of the visit, 16 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). The legal status of individuals subject to the Mental Health Act was clear and accessible on the day of our visit.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. At the time of our last we made recommendations in relation to appropriate use of T2 and T3 certificates. During this visit, we found all T2 and T3 certificates lawfully authorised treatments that were appropriately in place.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found paperwork for this.

For those people that were under the Adults with Incapacity (Scotland) Act 200 (the AWI Act) we found copies of Powers of Attorney (POA) or guardianship certificates in files with details of the POA or guardians clearly documented.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. For the individuals we reviewed who were subject to a section 47 certificate, we did not see as expected, the treatment plans that would have been on an annex 5 form. This is completed by the clinician with overall responsibility for the individual. The treatment plan should be written to include all the healthcare interventions that may be required during the time specified in the certificate. The treatment plan should be clear on whether the individual has capacity to make decisions regarding nutrition, hygiene, skin care, vaccinations, eyesight, hearing, and oral hygiene.

Recommendation 1:
Medical staff should ensure that, where a treatment plan is required for individuals subject to s47 certificate, it is completed using the recommended annex 5 form.

Covert medication refers to medicines given in a disguised form to individuals who refuse medication, are incapable of making decisions in relation to medical treatment, and where the medical practitioner deems the medication necessary. For patients who had covert medication in place, not all appropriate documentation was in order, as most had no recording of reviews or the pathway where covert medication was considered appropriate. The Commission has produced good practice guidance on the use of covert medication.

Recommendation 2:
Managers should ensure that covert medication care pathways are appropriately in place and reviewed.

Rights and restrictions

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. We reviewed the notes of individuals who were specified in Arran Ward. Despite the reasons for the restrictions applied being made clear in discussion with staff, as well as in the MDT meeting notes, there was no reasoned opinion recorded in the file. When an individual is specified, they should receive notification in writing about restrictions applied, timescales involved and right of appeal, unless doing so would be detrimental to their mental health. Whilst the information was shared verbally with individuals, there was no record of written notification being provided, or reasons why this would not be provided. We discussed these issues with managers on the day of the visit and were advised this would be followed up.

Recommendation 3:
When someone is made a specified person medical staff should ensure a reasoned opinion is clearly recorded. Managers should also provide individuals and any named person with written notification about the restrictions applied, timescales involved and right of appeal.

Managers should consider MDT training in the application and use of specified persons. Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patients' files, we look for copies of advanced statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We were pleased to see that the service had been promoting advance statements with all individuals by discussing this at the MDT meeting, and recording where an advance statement was in place and/or where an individual has refused.

Activity and occupation

Individuals we met with told us they had a good choice of activities including cooking groups, arts and crafts, walking groups, film sessions, gardening, music and relaxation. Individuals were also accessing community services, including local gyms and leisure centres. Many people receive one-to-one support from the OT service, which comprised of an OT, technician, and support worker. The files we reviewed contained comprehensive OT functional assessments, reviews, and structured activity planners. Individuals also received personal copies of weekly activity planners, and many told us they felt involved in decisions about activities.

Arran Ward has access to psychology services and is usually provided by two psychologists, however one post was vacant at the time of our visit. We noted that the current service focuses

on one-to-one psychology sessions, as opposed to wider psychological formulations to support and/or inform wider staff interactions with individuals. In discussion with managers, we were advised input from psychology services will be further developed when the current vacancy is filled.

We were pleased to see engagement in activities was being recorded and evaluated. Whilst there was clear motivation and commitment by all staff to engage people in activities, we heard from some individuals that weekend and evening times can be harder due to reduced activities on offer. We were advised that OT services are not available during these times, with activity support and coordination falling to nursing staff. Some staff we met with reported their ability to support activities can vary due to staffing pressures. Unlike other NHS GGC services, Arran Ward does not have access to patient activity co-ordinator (PAC) nurses. Support for activity is an essential part of rehabilitation and recovery. To ensure maximum benefit, the Commission are of the view that activities should be available to individuals throughout the week and in evenings. In discussion with managers, we highlighted the advantages PAC nurses offer individuals, particularly when nursing staff are pressured, and OT services remain unavailable at weekends.

Recommendation 4:
Managers should ensure that individuals have access to meaningful activity and occupation seven days per week.

The physical environment

The physical environment has continued to improve with artwork on display throughout the ward. The environment was bright and spacious, with access to larger and smaller communal areas, as well the courtyard and garden. The wider hospital grounds are overgrown and derelict. We heard from managers that some areas have been sold to developers who are progressing with plans to build private housing. It is hoped these plans will improve the appearance of the area and we look forward to seeing the progress on future visits. Some individuals were happy to show us their bedrooms which were personalised with photographs, posters, and belongings.

As noted at previous visits, some individuals require to share dormitories given the recovery part of the ward comprises single and dormitory rooms. One relative we met with told us that having a single room would offer their family member more privacy. We heard from staff we met with how some individuals prefer sharing rooms to reduce 'isolation'. However, it was also recognised in discussion with staff that choice cannot be offered to everyone due to limited availability of single rooms. Having access to a private bedroom is especially significant given some individuals in Arran Ward can be in hospital for lengthy periods of time. The Commission is of the view that individuals should be provided with single rooms to ensure their privacy is upheld and to better protect their dignity. We were pleased to hear from managers that a review of rehabilitation services is planned, which will consider our continued recommendations in relation to the provision of single rooms. The Commission are aware that other NHS GGC services have already been refurbished to provide single rooms and would strongly encourage managers to progress the same for Arran Ward.

Any other comments

We met with several staff, including the SN and the OT team, who told us they enjoy working in the service. We found that staff were motivated and committed to meeting the needs of diverse group of patients, despite the pressure on the service due to vacancies. We heard how pressures can be made more difficult by the moving nursing staff to provide cover in other services. We discussed these issues with managers on the day of our visit and were advised of ongoing recruitment plans. We were also informed that bank staff are used to support nursing staff vacancies and to provide additional cover during times of increased continuous nursing interventions.

Summary of recommendations

Recommendation 1:
Medical staff should ensure that, where a treatment plan is required for individuals subject to s47 certificate, it is completed using the recommended annex 5 form.

Recommendation 2:
Managers should ensure that covert medication care pathways are appropriately in place and reviewed.

Recommendation 3
When someone is made a specified person medical staff should ensure a reasoned opinion is clearly recorded. Managers should also provide individuals and any named person with written notification about the restrictions applied, timescales involved and right of appeal.

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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

Claire Lamza
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 Commission 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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