mentalwelfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Croy Ward**,** Ailsa Hospital**,** Dalmellington Road**,** Ayr KA6 6AB

Date of visit: 8 March 2017

Where we visited

Croy Ward is a fourteen-bed ward within the Ailsa Hospital campus in Ayr; the ward is designated for the assessment of functional mental illness in older adults. On the day of our visit there were seven inpatients.

We last visited this service in March 2013. At that time, we made recommendations in relation to the documentation of use and review of restraint; the need for reference to legal paperwork within electronic files; and the need for treatment authorisations to be up to date and accessible for treatment under the Adults with Incapacity (Scotland) Act 2000 (AWI) and Mental Health (Care and Treatment) (Scotland) Act 2003.

The intent of our visit to Croy Ward was not only to review the previous recommendations, but also to generally review the care and treatment being received by patients. We are aware that Croy is now one of only six wards remaining at Ailsa Hospital since the transfer of four adult wards to Woodland View Hospital in Irvine over the past 12 months. We were concerned about the impact this may be having on service delivery. In particular, we wondered what, if any, changes there have been to ward resources and whether staff feel sufficiently supported to deliver care and treatment to a high standard. We therefore wanted to meet with patients, carers, and staff members to hear more about this.

Who we met with

We met with or reviewed the care and treatment of four patients and met with two relatives.

We spoke with the ward manager; several members of nursing staff, including deputy charge nurses and one of the Carer Champions; a student nurse; the clinical nurse specialist (cognitive behaviour therapist); and an advocacy worker.

Commission visitor

Jamie Aarons, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The ward has three consultant psychiatrists; each with respective catchment areas within South and East health and social care partnership areas within NHS Ayrshire and Arran. Each consultant has a weekly multidisciplinary team meeting (MDT). These meetings generally include nursing staff, the pharmacist, and psychologist. There is little in the way of wider multidisciplinary input. Other services, including occupational therapy (OT), physiotherapy, or social work, can attend the MDT on a referral basis. We were informed that the OT input into the ward was greater and referrals were acted

on more efficiently prior to the move of wards to Woodland View. That being said, we were reassured that there are no issues around OT input into discharge planning; OTs complete functional assessments and onward referrals can be made to the community OT team if required.

Care plans have a good level of person-centred information and detail. There is evidence that care plans are updated regularly and weekly multidisciplinary team meeting minutes are thorough and easily accessible on the electronic recording system. Records include evidence that families are kept informed of care and treatment – with patient consent – and are involved in decisions. It was highlighted that there is no administrative support at MDT meetings, which means that nursing staff are responsible for taking minutes; this can detract from their ability to fully participate in the meeting.

It was noted that while the majority of records are completed electronically, some consultants continue to keep written records in paper format; this can be an issue when nursing staff are trying to find particular information or have difficulty reading written entries. Consideration should be given to all professionals consistently using electronic recording.

It was very clear that the nurses know their patients, their needs, and their carers. It was evident that relatives are encouraged to visit flexibly, with mealtimes protected. Relatives were very complimentary about the staff, their level of communication, the involvement of carers, and the quality of care delivered to patients. Patients with whom we spoke were also positive about the care they receive. We were very pleased to hear that efforts are made to help patients maintain links with their families and friends; these connections support the therapeutic work being done on the ward.

A psychologist has recently been introduced to provide input for Croy patients and their families, where appropriate. Nursing staff can contribute to psychological input between individual psychology sessions. As noted above, the psychologist attends the MDT meetings. We were also informed that patients can be referred to attend mindfulness sessions and there is a clinical nurse specialist who receives direct referrals for patients to be considered for cognitive behavioural therapy. The latter can continue to work with patients post-discharge, which provides continuity of this therapeutic input.

We were informed that the staff group within Croy work as a cohesive, supportive team. We heard that regular staff meetings occur and that a proactive approach is taken to identifying strategies that will be of greatest benefit to patient recovery. The team is comprised of individuals with a range of knowledge and experience, and we were informed that staff members are supported to attend training of interest and share this across the ward. For example, we were informed that medical cover is reduced overnight, so nursing staff are seeking to enhance their contribution to overnight

medical care needs, supported by a mental health advanced nurse practitioner. The staff team is complimented by student nurses.

In advance of the visit, we received information to suggest that some staff from mental health wards on the Ailsa Hospital campus may be feeling isolated since the move of the majority of mental health wards within NHS Ayrshire and Arran to the Woodland View site in Irvine. Within Croy, however, we were informed that staff feel sufficiently supported and feel that the move of other wards has brought them closer together as a staff group. Some changes to practice were required, including amendments to the process and timing of ordering medication as there is no longer a pharmacy on site. The staff team reported feeling well supported by ward managers and external managers; they were positive about meetings convened across Ailsa and Woodland View sites and feel this has contributed to a cohesive culture across services.

Use of mental health and incapacity legislation

We did not have any concerns on this visit regarding treatment authorisations. The electronic recording system provides prompts for staff regarding those patients receiving care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 to ensure that consideration is given to relevant legislation timeously. The electronic records included a note to advise where legal paperwork is held; this is accessible to hospital and community based staff.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) 2000 legislation must be completed by a doctor. Section 47 of the Act authorises medical treatment for people who are unable to give or refuse consent. Under s47 a doctor or other authorised healthcare professional examines the person and issues a certificate of incapacity. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. For the patients whose records we reviewed, where relevant we were satisfied that s47 certificates with accompanying treatment plans were present.

Rights and restrictions

On the day of our visit one patient was subject to the Mental Health (Care and Treatment) (Scotland) Act 2003.

In discussion with some staff we were concerned that there have been occasions previously when informal patients have expressed a wish to leave hospital and were repeatedly redirected and encouraged to remain in hospital. We are concerned that use of the Mental Health Act – and the safeguards it provides – may not have been considered for these patients. Nursing and medical staff must remain vigilant to indicators that a patient's informal status may no longer be appropriate. Where restrictions on a patient's freedom are being implemented without their informed

consent, consideration should be given to whether the patient is subject to an unauthorised deprivation of liberty and steps taken to remedy this.

Activity and occupation

Activity provision is limited, with no dedicated activity coordinator or regularly scheduled programme of activities. Most activities are undertaken on a one to one basis. We were satisfied that there were sufficient activities for patients, though for this to remain satisfactory staff must continue to prioritise the provision of meaningful and engaging activities for individuals.

In the absence of a ward-wide activity programme, activity care plans for individuals should continue to be person centred, reflecting the individual's preferences alongside activities specific to their care needs. This is an area that we will review at our next visit and we would like to be informed in the meantime of any significant changes to activity provision on the ward.

The physical environment

All bedrooms are single, with an en-suite. Patients reported that they are able to bring in items from home and no issues were raised by patients on the day of the visit regarding the ward environment. The sitting room is comfortably furnished, as is the ward's quiet room, which is also used for visitors.

The ward has a pleasant, secure courtyard garden that is easily accessible by patients directly from the current sitting room. The garden is well maintained and used regularly. We were informed that consideration is being given to swapping the current dining and sitting room spaces, which are either side of a large open plan area. This would require a section of non-carpeted flooring to be installed in the current sitting room area, but would mean less disruption to those in the sitting room when patients access the garden.

We were pleased to see that the therapy kitchen is readily accessible to patients, both with and without staff assistance (depending on individual risk assessment). Patients can bring in their own food to prepare, which contributes to skills maintenance while in hospital and provides an on-site resource for relevant occupational therapy assessments.

We were also informed by patients and staff about the on-site gym. Following physiotherapy assessment, patients can access the gym with or without staff, depending on individual assessment and suitability. Several patients spoke favourably about the gym access and the positive impact this has had on their recovery.

Any other comments

We were informed that some patients can find the ward meals too restrictive; we were told that due to amendments to the porter service, evening meals are served to Croy's patients very early and cannot be reheated. While patients can bring in their own food, this is not an ideal alternative to receipt of hospital meals and is not a realistic option for everyone. Options for vegetarian patients are limited; this was raised on the day of our visit and staff took steps, with the support of the dietician and in liaison with catering staff, to try to improve this as soon as possible.

We would wish to receive an update on progress made in three months' time.

Summary of recommendations

We did not make any recommendations from today's visit.

Good practice

We were informed that the ward has two 'Carer Champions' and the service has implemented guidance from the 'Triangle of Care'. This includes written information provided to carers when a patient has been admitted; the ward has adapted some of the 'Triangle of Care' work to reflect a more positive outlook on hospital admission. We were shown a copy of a letter that goes to carers within 48 hours of admission, which invites carers (when patient permission has been granted) to meet in a way that is most convenient for them and to contribute to care planning. The Carer Champions, and other nursing staff, endeavour to link carers to relevant community groups so that carers feel sufficiently supported.

The ward has two volunteers starting soon, who will spend time engaging patients in activity, depending on the patients' stages of recovery. Whilst it was acknowledged that volunteer support of this kind is not a substitute for an occupational therapist or activity coordinator, the ward's engagement of volunteers is commendable.

Service response to recommendations

As there are no specific recommendations from this report, the Commission does not require a formal response. We would like an update on the issues raised regarding meal provision and would like to be informed of any significant changes to the provision of activities for patients.

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.

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