Mental Welfare Commission for Scotland

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

Date of visit: 8 March 2017

Where we visited

Dunure Ward is a 15-bed ward within the Ailsa Hospital campus in Ayr; the ward is designated for the assessment of organic mental illness in older adults. On the day of our visit there were 14 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; 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; and we reviewed activity provision on the ward. When we last visited, the ward had 22 beds; this was reduced to 20 beds before a further reduction was made to establish the current 15-bed resource.

The intent of our visit to Dunure Ward was not only to review the previous recommendations, but also to generally review the care and treatment being received by patients. It was recently brought to our attention that service provision has been effected by the transfer of most other mental health wards from the Ailsa Hospital site to Woodland View Hospital in Irvine. We received information that some staff have been feeling isolated, with subsequent impact on service delivery. We therefore wanted to meet with patients, carers, and staff members to hear more about this.

Who we met with

We met with five patients and reviewed their care and treatment through care files and discussions with staff; additionally, we reviewed the records of one patient who was not able to be interviewed at the time of our visit. We also met with the relatives of three patients.

We spoke with the senior charge nurse and several members of nursing staff throughout the day.

Commission visitors

Paul Noyes, Social Work Officer

Mary Hattie, Nursing Officer

Jamie Aarons, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The ward has three consultant psychiatrists; they are each responsible for patients from one of the three 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 very 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 prior to the move of wards to Woodland View.

We were advised that there is currently a two-month waiting list for psychology, but when the psychologist is involved they contribute to the care planning for management of stressed and distressed behaviour.

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 very clear that the nurses know their patients, their preferences, and their carers. It was evident that relatives are encouraged to visit flexibly, with mealtimes protected. Relatives were very complementary 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, friends, and even with pets; these connections support the therapeutic work being done on the ward.

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.

Staff appear knowledgeable regarding Adults with Incapacity and guardianship processes. Where patients have a proxy decision maker – either power of attorney or guardian – we found relevant paperwork on file and an alert on the electronic recording system to ensure staff awareness of the proxy decision maker.

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.

There is a weekly hairdresser and regular therapet visits. Arrangements have also been made for one patient's own hairdresser to come in regularly. A student from the local college attends to do manicures and there was evidence that some person-centred activities are arranged. One patient informed us of regular chats between patients and staff. Several patients have time out of the ward with their families, and visits from families are actively encouraged, including time with grandchildren and pets.

While there was evidence of thought going into individualised activities, in the absence of a dedicated resource activity, provision could be developed and improved. Based on discussions with staff, we were particularly interested in whether there is a correlation between incidents of aggression and distress in the evenings, with a smaller staff complement and decreased activity provision at those times.

As noted above, due to the majority of allied health professional services moving to the Woodland View site occupational therapy and physiotherapy services are less accessible than they were previously.

Recommendation 1:

The ward manager should conduct an audit of incidents of stressed and distressed behaviour.

The physical environment

On the day of our visit the ward appeared calm and clean. However, the ward is not ideal for the delivery of care and therapeutic services. The day room and dining room spaces are in the central core of the unit, have no windows and have little natural light. The décor of the ward is shabby and tired.

Bedroom door windows do not have privacy blinds, and there are large windows at corridor ends that lack blinds. Lack of privacy screening compromises patient dignity.

We were informed that there are also problems with the heating; staff have no ability to control this and the ward can be either too hot or too cold.

We were shown broken railings, loose radiator guards, curtains half off the rails, and signage pulled off walls. There is little dementia signage, particularly as some of what was previously provided has been removed by patients and has not been replaced. Also, a water fountain in the dining room has been broken for over three months, resulting in patients requiring staff intervention to access a drink.

We were informed that there are problems getting maintenance issues addressed; all issues brought to our attention during the visit have been reported but not yet repaired.

Dunure Ward was, until recently, a 20-bed unit. The reduction from 20 beds to 15 beds has allowed for the creation of four visitor rooms. These rooms include comfortable couches that allows people to sit beside each other, as well as chairs; a small table; and tea and coffee making facilities. The rooms also include access to wireless internet connections, which allow relatives to share social media or other sites of interest with their loved one.

The ward has a pleasant, secure courtyard garden. This is well-maintained and used regularly.

Recommendation 2:

Managers should undertake a dementia environment assessment and implement the findings from this.

Recommendation 3:

The ward manager should complete an audit of bedroom doors and windows, and take steps to ensure patient privacy and dignity is safeguarded.

Recommendation 4:

Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable; a system should be implemented to ensure that maintenance requests are responded to within a reasonable timeframe.

Any other comments

We were informed that four patients are currently delayed discharges; at present, these delayed discharges are predominantly due to difficulties in finding suitable care homes for these patients. However, we were also told that delays occur when awaiting the granting of welfare guardianship with relevant powers to enable a patient to be

legally transferred to and supported in the community. We heard that delays in discharge can occur when local authorities are not using the range of legislative provisions available to facilitate discharge, including s13ZA of the Social Work (Scotland) Act 1968. We are aware that there are inconsistencies in use of s13ZA both locally and nationally. We are aware that discussions are ongoing between the three partnerships within NHS Ayrshire and Arran to address these inconsistencies and minimise unnecessary discharge delays while adhering to the principles of the Adults with Incapacity (Scotland) Act 2000. We would like to be kept informed of progress on this subject.

Some staff reported feeling isolated and vulnerable since other wards moved to Woodland View; there are only five wards remaining on site. In the past, Dunure staff were reassured that if additional input was required on a time-limited basis, they could call on colleagues from other wards. Access to support is now more limited.

However, there has been an increase in the level of training in management of aggression provided to staff to try to address this. Staff are also engaged in the NHS Education for Scotland (NES) Excellence in Practice training programme and the Newcastle Model is being introduced for managing stress and distress. This psychosocial model provides a framework and process in which to understand behaviour that challenges in terms of needs that are unmet, and suggests a structure in which to develop effective interventions that keep people with dementia central to their care.[1]

Summary of recommendations

1. The ward manager should conduct an audit of incidents of stressed and distressed behaviour. If a higher rate of stressed and distressed behaviour is identified in the evenings, consideration should be given to enhancing the staff compliment and/or activity provision at certain times in the evenings.
2. Managers should undertake a dementia environment assessment and implement the findings from this.
3. The ward manager should complete an audit of bedroom doors and windows, and take steps to ensure patient privacy and dignity is safeguarded.
4. Managers should ensure that outstanding repair and refurbishment work is undertaken as soon as practicable; a system should be implemented to ensure that maintenance requests are responded to within a reasonable timeframe.

Good practice

As noted above, we were impressed by the four visitor rooms, which were created with funding contributions from relatives and fundraising efforts by staff. These rooms provide a comfortable and peaceful environment in which relatives and carers can

[1] https://www.ncbi.nlm.nih.gov/pubmed/25727635

meet with their loved ones. We were struck on the day of our visit by the opportunity these rooms offer for relaxed and natural interactions between patients and their carers. We were informed that the rooms are very well used and are highly valued by relatives.

Positive mention was made of the liaison nurses who work between the ward and care homes in the community. According to staff, the liaison service has directly prevented hospital admissions and has served to support patients following discharge from the ward.

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.

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