mental welfare commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Arrol Park, Houses 4, 5 and 6 Doonfoot Road, Ayr KA7 4DW

Date of visit: 17 November 2016

Where we visited

Arrol Park is an NHS Assessment and Treatment unit for people with a learning disability who require a period of inpatient care due to additional difficulties such as mental health problems, which cannot be managed at home. There are 16 assessment and treatment beds divided across three wards, 14 of which were occupied at the time of our visit. There is an additional ward – House 7 – that provides a longer stay service for two patients in a forensic setting. We also visited House 7 on the day of our visit to Houses 4, 5, and 6; this was part of our national visits to forensic services in 2016 and will not be reported on here.

We last visited this service on 24 September 2015. This was part of our national visits to learning disability inpatient units 2015. At that time, we identified some areas for improvement. An Action Plan was provided by the service, inclusive of steps they would be taking to address recommendations made on a local and national level. On the day of this visit we wanted to follow up specifically on those areas identified for improvement within Arrol Park. We recommended that:

- Care plans should be outcome-focused with clear intervention strategies and review dates.
- Treatment authorised under the Mental Health (Care and Treatment) (Scotland) Act 2003 should be specific to mental health related treatment.
- Treatment for physical healthcare under the Adults with Incapacity (Scotland) Act 2000 legislation should be clearly recorded by means of a s47 certificate.
- Signage on the wards should be improved to reflect the communication needs of the patient population.
- We were concerned about staff understanding of “deprivation of liberty” in one particular case.

Commission visitors

Jamie Aarons, Social Work Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We were pleased to see that work is continuing to devise a Positive Behaviour Support Plan (PBS) for each patient currently receiving treatment, though at present there are only three patients with a PBS plan (with three more underway). We found that outcome-focused care plans are increasingly becoming standard for Arrol Park, with visitors noting that the care plans of more recent admissions were more consistently outcome-focused as compared to those of longer-stay patients.

Where a PBS Plan already exists for a patient, we noted clear and consistent record of proactive strategies to reduce stressed or distressed behaviour, and intervention strategies aiming to decrease use of restrictive practices. Management of behaviours that challenge is well-documented within care files. We welcome the continued goal of patients having a PBS Plan that includes proactive intervention strategies and an outcome-focused activity planner.

Patients and staff confirmed that, whenever possible, patients are invited to attend their weekly reviews with their psychiatrist, inclusive of the fuller multi-disciplinary team.

Feedback from patients and a relative was positive regarding the care and treatment received at Arrol Park. We were made aware that families receive beneficial written and verbal information at the time of patient admission; this is often first shared with them by community-based staff, to reduce anxieties about the admission process. The wards use a flow chart and admission checklist on admission to promote continuity, consistency, and good practice with patients and their relatives.

We were impressed to see the carer and patient post-discharge questionnaires being piloted. These appear to be an effective means of engaging patients and carers to gain their feedback about experiences during admission. We are hopeful that this successful pilot can be embedded in permanent practice, promoting patient and carer participation; we were told that consideration is being given to how this may be rolled out to community staff to take forward in the future. Patients and carers are also encouraged to access Patient Opinion online, in order to leave any comments.

Use of mental health and incapacity legislation

As noted above, we were looking specifically for appropriate use of treatment authorisations for mental and physical health care. Section 47 of the AWI 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. We were informed that an audit of T2s, T3s and Section 47 certificates was completed following our last visit; the outcome of this was that the issues we identified are now resolved. T2s and T3s we saw today are completed specifically in relation to mental health treatment. Section 47 certificates are considered for all patients, then stored in several relevant places.

We were informed that consideration is being given to adding a “legal” tab to the current electronic recording system. We would welcome this development as a means of ensuring that hospital and community staff are easily able to find a patient’s legal status.

Rights and restrictions

During our meeting with the wards' psychiatrists we spoke about previous concerns regarding unauthorised deprivation of liberty. We found the responsible medical officers (RMOs) to give thoughtful consideration to all patients' detention status and we did not have any concerns in relation to patient rights and restrictions on the day of this visit.

We were made aware that patients from one particular area (North Ayrshire) can find access to advocacy difficult. We were advised that advocacy services for North Ayrshire are currently being reviewed. We would like an update on how access to advocacy for these patients has progressed.

Activity and occupation

We were informed by staff that recent crisis admissions have had an impact on the implementation of a particular patient's activity and discharge plans. We are also aware that there was a recent period where patient activity was limited due to staff absence. However, we were told the staffing compliment is generally adequate to meet the needs of the service. Activity planners are currently being devised that will include goals for patients, in addition to a "comments" field that can be used to record missed activities and the reason(s) for this. Robust evaluation can then occur to graph activity provision and a patient's participation record.

Activities can now be facilitated more regularly through use of the new hospital bus. This is used regularly to allow patients access to community-based activities and has been adapted to minimise risk to patients and staff during transport.

We were informed that physical activity needs to be promoted on the wards. Arrol Park does have a hydrotherapy pool on site but this is not being used due to a lack of staff trained to oversee its use. Other suggestions for activity inclusive of exercise were being explored, including use of a trampoline or dog walking.

The physical environment

We were happy to see the results of the successful endowment bid to fund artists to paint murals within the wards. This has added welcome colour and improved the look of each of the wards.

There has been some improvement in the user-friendly communication present on the walls, including easy read signage located outside each ward to indicate protected mealtimes, visiting hours, medication rounds, and medical visits. We were informed that there has been some progress made in implementing individual storyboards to aid communication, but there continues to be a lack of adequate signage for this patient group throughout the wards.

Recommendation

The ward manager should continue to make the ward environment more inviting and improve signage based on the communication needs of the patient group.

Good practice

As noted above, we found good practice in situ to promote patient and carer participation both during and following admission. The post-discharge pilot questionnaires can be used to help the service develop, and provide an element of continuity between inpatient and outpatient services following discharge. We are hopeful that the success of this pilot programme will mean that it can become part of permanent practice and be shared across other services.

Service response to recommendations

The Commission requires a response to the recommendation made within three months of the date of this report.

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

Jamie Aarons
Social Work Officer

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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