Mental Welfare Commission for Scotland

Report on announced visit to: Iona/Lewis and Jura Wards Ailsa Hospital**,** Dalmellington Road**,** Ayr KA6 6AB

Date of visit: 4 May 2017

Where we visited

Jura ward is a 15 bed ward within the Ailsa Hospital campus in Ayr; the ward is designated for the continuing care of adults with diagnosis of dementia. On the day of our visit there were 11 inpatients.

Iona/Lewis ward is also a 15 bed ward, but is designated for palliative care for adults with complex mental illness. Patients typically are over 65 years old and have a diagnosis of dementia, but there is flexibility with admission criteria dependent on patient need. On the day of our visit there were 10 inpatients in Iona/Lewis Ward.

The intent of our visit to these wards was to review the care and treatment being received by patients, including activity provision; to review use and staff awareness of the Adults with Incapacity (Scotland) Act 2000 (AWI) and Mental Health (Care and Treatment) (Scotland) Act 2003; and to consider how patient rights are being safeguarded. We are aware that Iona/Lewis and Jura wards are now two of only six wards remaining at Ailsa Hospital since the transfer of most other 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 10 patients and met with six relatives.

We spoke with the clinical nurse manager; each of the ward managers; several members of nursing staff, including deputy charge nurses; a ward doctor; a student nurse; and an advocacy worker.

Commission visitor

Jamie Aarons, Social Work Officer (visit coordinator)

Moira Healy, Social Work Officer

Claire Lamza, Nursing Officer

Kathleen Taylor, Engagement and Participation (Carer) Officer

What people told us and what we found

Care, treatment, support and participation

We were informed by staff that the dynamic of Jura Ward has changed since originally being designated as “continuing care.” Staff with whom we spoke advised that the turn-over of patients is now higher than it had been in the past, and they are regularly providing support to patients with complex, challenging, stressed and distressed behaviour. Staff report significant clinical demands and felt strongly that their function is atypical of “continuing care” wards generally due to the complexity of patient mental health needs, which cannot be met in community settings at present. We were

informed that patients are typically received to Jura Ward from Dunure Ward and that Jura plays a role in preventing a bottleneck in admission wards.

The wards share one consultant psychiatrist and also have input from a ward doctor who is in the wards frequently. Nursing staff with whom we spoke provided positive feedback in relation to the medical cover on the wards, advising that they feel well supported, listened to, and valued. We also noted that the whole staff groups on both wards worked together as cohesive teams. It was evident to us through conversations and observations that from domestic staff to the senior charge nurse (SCN); the student nurse to the ward doctor, staff are working as a team to provide support for each other and the best possible care for the patients. We were also advised that, when needed, staff are available from other wards to cover times of increased clinical demand.

Prior to our visit, we were made aware that a concern had been raised about the potential isolation of these units from the services based at the main site, Woodland View, in Irvine. We asked staff about this when we visited, and although there was a sense that the future of the units is unclear, staff told us they feel sufficiently supported. The staff are using the SPSP collaborative “morning huddle” where all wards look proactively at the wards requirements, to ensure patients’ needs are met and that staffing resources were maximised.

There has also had to be other adaptations to the day-to-day routine, including amendments to the process and timing of ordering medication as there is no longer a pharmacy on site.

The consultant has a monthly ward review, inclusive of nursing staff. There is little in the way of wider multidisciplinary input. Other services, including occupational therapy (OT), physiotherapy, psychology, dietetics or social work, can attend the review meetings on a referral basis but there is no dedicated time for any of these professionals to the wards. It was highlighted to us by staff and a relative that chiropody input for patients has reduced since the transfer of wards to Woodland View, and it was felt that the electronic referral system can be problematic in that ward staff can confirm when a referral has been made but are unable to identify when an appointment will occur. Jura ward staff are soon to be receiving basic foot-care training so that they can provide input between chiropody appointments.

Due to the limited, referral-only input from psychology, we were advised that nursing staff on Jura Ward are due to receive training on psychological interventions, particularly in relation to stressed and distressed behaviour. We were pleased to hear that nearly all staff have received dementia-related training in keeping with the Promoting Excellence education framework; it was noted that managers have been supportive of this initiative and that staff have improved attitudes toward and understanding of working with people with dementia.

Care plans have a good level of person centred information and detail. There is evidence that care plans are updated regularly and monthly multidisciplinary ward review minutes are thorough and easily accessible on the electronic recording system. Records include evidence that families are kept informed of care and treatment and are involved in decisions, though it was noted that families are only formally invited to attend the 6-monthly reviews. Jura Ward uses the Newcastle Model to understand

stressed and distressed behaviours within their dementia population. They have introduced behaviour monitoring charts and we would encourage their continued review and use of the information gathered to guide intervention strategies for individuals.

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. Relatives were very complimentary about the staff, their level of communication, the involvement of carers, and the quality of care delivered to patients. We met with one carer who expressed some concerns regarding her inclusion in care planning and delivery, and particular aspects of her relative's care and treatment. These issues were discussed on the day and were being dealt with by staff.

Use of mental health and incapacity legislation

There were no patients in any of the wards under formal measures of the Mental Health (Scotland) 2003 Act. The electronic records included a note to advise where legal paperwork is held; this is accessible to hospital and community based staff.

Several patients receive medication covertly, and had covert medication pathways in place. We did not consistently see that covert medication was included on the Section 47 certificate. A copy of the S47 certificate, treatment plan, and covert medication pathway should be stored with the drug prescription sheet.

We noted that across both wards there appears to be a low level use of "as required" medication for managing stressed and distressed behaviour, and we were reassured to hear that no intramuscular "as required" medication is prescribed for informal patients.

Nearly all patients have either a power of attorney or welfare guardian in place. In Jura, we found that staff had knowledge of Adults with Incapacity (AWI) legislation and were including proxy decision makers in discussions, when relevant. We noted that each ward has commenced requesting pertinent paperwork from guardians and powers of attorney, but paperwork was not always in the file and in some instances on Iona/Lewis there was confusion regarding the differences between guardians and powers of attorney and what information is required. We referred the wards to our information leaflets on AWI and our *Good practice guide: Common concerns with Powers of Attorney*, in addition to our AWI checklist.

Recommendation 1:

Senior Charge Nurses (SCNs) should ensure that where a patient is in receipt of covert medication, that this is included on the section 47 certificate.

Recommendation 2:

The senior charge nurse of Iona/Lewis should pursue training for staff in relation to Adults with Incapacity legislation; particularly guardianship and power of attorney to ensure staff awareness of the differences between the two and relevance of proxy decision makers to patients.

Recommendation 3:

Senior charge nurses should audit all files and ensure relevant AWI certificates and powers are on file. We recommend use of the Commission's AWI checklist in each file.

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

On Jura ward we noted that 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 and visits from families and friends are actively encouraged. We would expect to see activity care plans for individuals to be person centred, reflecting the individual's preferences alongside activities specific to their care needs and goals. While there was evidence of thought going into some individualised activities, in the absence of a dedicated activity resource provision could be developed and improved. We were made aware that due to clinical demands nursing staff do not have sufficient time to coordinate or run activities.

Within Iona/Lewis, we were informed of "Namaste," a therapeutic way of working that includes the provision of massage, aromatherapy, and music therapy. Each patient on Iona/Lewis has their own "playlist for life;" some patients are more receptive to this than others but for those for whom music is important this medium is used throughout the day to either stimulate or relax and calm the individual.

Recommendation 4:

The senior charge nurse of Jura should ensure that activity care plans are person centred, reflecting the individual's preferences alongside activities specific to their care needs.

The physical environment

All bedrooms are single and en suite. Bedrooms were personalised and it was clear that patients and relatives are able to bring in items to reflect individual tastes. Both wards were noted to be clean and bright, although there is limited natural light. The sitting rooms are comfortably furnished, with additions of cushions and pictures to create as homely an environment as possible. This was particularly true of Iona/Lewis,

which was also noted to have fresh flowers on the day of our visit. However, we were disappointed to hear that the en suite toilets do not have doors. We understand that when the units were built, the en suites were not meant to have doors; at a later point curtains were added, but removed as they were thought to be a ligature risk. We were advised that a couple of the en suites now have doors and that there is bid for this to happen to all en suite bathrooms.

The entrance to Jura Ward is down an uninviting corridor and we noted on the day that the temperature on the ward can be uncomfortable; there is very little potential for fresh air onto the ward and the thermostat cannot be amended from the ward (staff must contact Estates to amend). In addition to poor temperature control, we were advised that lighting on Jura Ward is poor for the purposes of staff conducting some clinical activities including blood draws and dressing application. Where there is poor lighting, there can be an increase in trips and falls for people with dementia; good lighting helps individuals with this diagnosis see what is around them, they can navigate their environment better as they can more clearly see staff faces and other signs and landmarks in the area.

We were made aware that funding for improvements has been approved, but that changes have still not been made and it is approximately six months since approval was given.

The wards were, until recently, 20-bedded units. The reduction from 20 beds to 15 beds in each ward has allowed for the creation of visitor rooms. These rooms include comfortable couches that allow people to sit beside each other, as well as chairs; a small table; and tea and coffee making facilities. Relatives spoke fondly of these rooms and they are used regularly. Iona/Lewis Ward also has a family room, which can be used as a guest bedroom to enable relatives to spend the night. We welcome that Jura Ward is intending to replicate this guest bedroom provision.

While in-ward visiting arrangements were very positive, we were informed that there can be limited disabled parking spaces for visitors; we were advised that disabled spaces can be taken by people who do not have the relevant permits. It was also brought to our attention that there are limited café or shop facilities on site.

The wards have a shared garden, though we were advised that patients from Jura do not use theirs regularly due to its uneven surfaces and limited staff time to maintain the garden. Jura's garden has potential to be separated to make an individual ward garden, which could promote its security for vulnerable patients (because there would not be a risk of them leaving through a neighbouring ward's unlocked door). It was noted that the ward may have some volunteers soon to assist with garden maintenance, which would be welcomed input.

Recommendation 5:

The hospital manager should ensure that Jura's garden area is maintained to provide a safe, pleasant, and easily accessible area for patients and visitors.

Recommendation 6:

The hospital manager should ensure that any outstanding repair and refurbishment work, including amendments to Jura Ward's lighting, is undertaken as soon as practicable.

Recommendation 7:

The hospital manager should move forward with investing in refurbishment work to the en suite toilets, to promote the dignity of patients.

Summary of recommendations

1. SCNs should ensure that where a patient is in receipt of covert medication, that this is included on the Section 47 certificate.
2. The SCN of Iona/Lewis should pursue training for staff in relation to Adults with Incapacity legislation; particularly guardianship and power of attorney to ensure staff awareness of the differences between the two and relevance of proxy decision makers to patients.
3. The SCN should audit all files and ensure relevant AWI certificates and powers are on file. We recommend use of the Mental Welfare Commission's AWI Checklist in each file.
4. The SCN of Jura should ensure that activity care plans are person centred, reflecting the individual's preferences alongside activities specific to their care needs.
5. The hospital manager should ensure that Jura's garden area is maintained to provide a safe, pleasant, and easily accessible area for patients and visitors.
6. The hospital manager should ensure that any outstanding repair and refurbishment work, including amendments to Jura Ward's lighting, is undertaken as soon as practicable.
7. The hospital manager should move forward with investing in refurbishment work to the en-suite toilets, to promote the dignity of patients.

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)

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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