Mental Welfare Commission for Scotland

Report on announced visit to: Scolty Ward, Glen O'Dee Hospital, Corsee Road, Banchory AB31 5SA

Date of visit: 19 February 2018

Where we visited

Scolty Ward is an older adult assessment unit for people with dementia, co-located on the same site as the community hospital ward. It has 12 available beds. On the day of our visit there were eight patients on the ward. We last visited this service on 1 May 2014, and made recommendations in relation to the locked door policy and welfare proxy powers.

On the day of this visit, we wanted to follow up on the previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of six patients.

We spoke with the charge nurse and other clinical staff.

Commission visitors

Douglas Seath, Nursing Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We observed that interaction between staff and patients was friendly, supportive and enabling. Activities were observed to be taking place and descriptions of activity sessions were recorded in notes.

Safety risk assessments were carried out for all patients on admission, and recovery plans were developed from these. Care plans we read on the day, though well organised, did not have specific interventions which related to the particular needs of each individual. Although it was good to see care plans for stressed and distressed behaviour, we felt these could have been more comprehensive and person centred. Interventions such as ‘use distraction techniques’, which related to a patient whose behaviour was, at times, agitated or distressed, rarely described what distraction techniques would be useful for that person.

In addition, care plan reviews were generally not meaningfully evaluated, staff simply recorded dates when reviews were carried out. Therefore, this did not describe how the plan was working and did not detail any amendments, which may be needed to improve the interventions listed.

Physical health care plans were generally of a high standard.

There is good pharmacy input into the unit, with regular pharmacy involvement in the multidisciplinary team (MDT) reviews.

The record of MDT meetings were detailed and listed all those present. Communication with families also appeared to be good, with a communication sheet in files and a record of discussion in preparation for discharge. The work in this area stems from a greater awareness of the 'triangle of care' initiative. There was also a liaison nurse and outreach team to assist with transitions. A post discharge questionnaire was also being piloted to determine satisfaction with the service.

From the files we examined, personal history profiles were generally variable with many of the 'Getting to Know Me' forms incomplete.

Recommendation 1:

Managers should develop nursing care plans which include more individualised interventions and an evaluation of each intervention when the care plan is reviewed.

Use of mental health and incapacity legislation

Each file had an index form detailing any powers of attorney, welfare guardians and s47 certificates of incapacity under the Adults with Incapacity (Scotland) Act 2000 (AWI). Where an individual lacks capacity in relation to decisions about medical treatment a certificate completed under s47 must be completed by a doctor. It must cover all relevant treatment that the individual is receiving. All s47 certificates were in place with accompanying treatment plans using the Grampian specific documentation. Covert medication pathways were also fully completed.

Documentation under the Mental Health (Scotland) Act 2003 (MHA) including consent to treatment forms (T2) and forms authorising treatment (T3) were in place as required. All T2/T3 forms were completed as appropriate and could be located within the medication charts. One minor issue with a prescription was highlighted and resolved on the day.

In most of the case files we reviewed, where there was a welfare proxy (guardian or power of attorney), a copy of the powers was in place. This helps to ensure that discussion has been had, regarding decisions made, between the staff and the legally authorised proxy.

Rights and restrictions

As the patients in the ward all have a diagnosis of dementia, the external fire door to the ward is locked to maintain safety and to prevent patients leaving the ward unnoticed. All staff have a key should the door need to be unlocked in an emergency. A locked door policy is in place and reviewed regularly, and information about this is contained within information booklets given to relatives and patients on admission. Information about the locked door policy is displayed at the door of the ward. Staff reported that there were no issues in respect of unauthorised deprivation of liberty and we did not witness any during our visit.

Activity and occupation

Therapeutic activities care plans were present in patient files and we observed staff spending time with patients in the day room on the day of the visit. In addition to her functional assessment work, the occupational therapist (OT) also runs a cognitive stimulation group weekly.

Encouragingly, the ward had volunteers from the local school, who 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 OT or activity coordinator, the ward's engagement of volunteers is commendable.

Plans are in place to increase the activities available to patients by recruiting a staff post on a contract giving 12 hours per week

The physical environment

The environment was spacious and appropriate for the patient group. We noted use of dementia friendly signage. There were also dementia friendly rummage drawers, doll therapy aids, a games room and space for activities to take place. The day room is a patient only area, and visitors must use other rooms provided. This is to give patients more privacy. There was a dedicated room for visitors in an annexe of the activities room. There was also a room available for relatives to stay overnight where patients may be receiving palliative care.

Flooring was consistent throughout. Access to a suitable outside garden area was available, though in need of some upgrading. Efforts were being made to find assistance to help with this. The sliding doors to the bedrooms are also difficult to operate for patients with cognitive impairment.

One major issue was the lack of suitable bathing facilities. The ward had one very large bath, with lifting equipment for patients with physical disability, which must be quite daunting for patients used to a standard sized bath. Additionally, there was only one shower room available for the whole ward. This lead to a difficulty reported by nursing staff in assisting all patients to bathe every day, should they wish to do so.

Recommendation 2:

Managers should review the bathing arrangements to ensure that there are adequate and suitable bathing facilities for all patients.

Any other comments

The ward has developed a very useful admission pack with information on the ward for patients and visitors arriving at the ward for the first time.

Summary of recommendations

1. Managers should develop nursing care plans which include more individualised interventions and an evaluation of each intervention when the care plan is reviewed.

2. Managers should review the bathing arrangements to ensure that there are adequate and suitable bathing facilities for all patients.

Good practice

We were pleased to hear that a number of staff have received dementia-related training online, 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.

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 Thompson
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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