mentalwelfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to:

North and East Wards, Dykebar Hospital, Grahamston Road, Paisley PA2 7DE

Date of visit: 6 December 2017

Where we visited

North and East wards each have 21 en-suite bedrooms and provide care for people with dementia who require continuing NHS care due to their complex needs, or stressed and distressed behaviour. North Ward is a male ward, East Ward is for females. At the time of our visit both wards were full with a total of 11 patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. We last visited this service on 3 February 2016 and made recommendations about care planning, access to psychology, restraint, physical environment, staffing levels and training.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at life history information and activity provision. This is because of their importance in providing good quality dementia care.

Who we met with

We met with and/or reviewed the care and treatment of 15 patients and met with seven carers/relatives.

We spoke with both senior charge nurses (SCN), the physiotherapist and the occupational therapist (OT).

Commission visitors

Mary Hattie, Nursing Officer

Mike Diamond, Executive Director (Social Work)

Margo Fyfe, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The ward has regular physiotherapy and OT input, and can access other specialist services, such as speech and language therapy and dietetics by referral.

The ward now benefits from regular input from a clinical psychologist. We are aware that one of the SCNs has completed the NHS Education Scotland (NES) Dementia Specialist Improvement Lead training. They are therefore now able to provide training in the management of stress and distress to other staff, in conjunction with the psychologist. A timetable for delivering this is currently being developed.

Care plans in both wards are person centred and reviewed regularly. However, staff need to ensure that proxy decision makers are involved in care plan discussions. The level of detail within care plans for management of stress and distress varied with

some excellent examples, including details of triggers and effective distraction techniques for the individual. Others simply stated distraction techniques should be used. From our discussions, this will be addressed as part of the above training. We look forward to seeing the outcome of this on our next visit.

Most patients had completed ‘Getting To Know Me’ forms on file, however the level of detail contained in these varied, and there was no other life history information recorded. Given the importance of life history information in formulating person centred care plans, this is an area for further development.

Six monthly multi-disciplinary team (MDT) reviews are well documented, and the need for continuing NHS placement is considered. However, there could be greater clarity around treatment goals to ensure continuity.

Physical health care is well care planned for and routine physical health checks are carried out prior to each six monthly review.

Both wards are involved in a project to enhance their ability to deliver palliative care. The consultant from the hospice will visit the ward monthly, one staff nurse on each ward leads on the project and will have the opportunity to work shadow shifts in the hospice to develop their skills. The lead nurses have recently met with all staff to discuss their training and support needs, and will be developing sessions to address the identified needs. The staff grade will also receive five days training within the hospice.

Relevant palliative care information is being kept alongside do not attempt cardiopulmonary resuscitation (DNACPR) paperwork for ease of access.

A traffic light system is being developed which will assist in identifying changes in patients’ needs and stage.

Recommendation 1:

SCN should ensure that life history is easily accessible within the care file and should be used to inform person centred care.

Use of mental health and incapacity legislation

All compulsory treatment order (CTO) paperwork was easy to find, forms authorising treatment (T3) were in place where required.

Where patients had proxy decision makers, this was clearly recorded in the files along with a copy of the powers. All proxies spoken to confirmed that they were consulted and involved appropriately. All patients whose files we looked at had s47 certificates of incapacity and treatment plans in place.

Where patients were receiving covert medication, pharmacy had been consulted and detailed guidance provided. However, for several patients on covert medication we could not locate a copy of a completed covert medication pathway.

Recommendation 2:

SCN and Responsible Medical Officer (RMO) should ensure that patients receiving covert medication have a completed covert medication pathway in place. This will ensure that there is an appropriate legal framework and proxies have been consulted.

Rights and restrictions

Both wards have doors secured by a key pad entry system. Visitors enter and exit with the assistance of nursing staff. No patients are able to leave the ward safely on their own. Where a patient is indicating their desire to leave the ward their detention status is reviewed and the Mental Health (Care and Treatment) (Scotland) Act 2003 is used if necessary.

There is a pleasant secure garden which has direct access from the ward sitting rooms. We are advised this is well used when the weather allows.

North Ward has an activity co-ordinator in place. Due to pressures on the nursing establishment, East Ward no longer has this post. Both wards benefit from regular OT and OT assistant sessions. Within East Ward, we are advised that, whilst there are regular activities, rather than a pre-planned programme, provision is flexible to meet the changing needs of the individual patients. Also, that the majority of activities are on a one-to-one basis due to the needs of the patient group. There is a view that staff often do not recognise and record much of the one-to-one activities provided.

Within North Ward, there is a regular programme of activities, including football, memories sessions, quizzes and music sessions, as well as a range of individual one-to-one activities.

Both wards benefit from Therapet sessions and wandering minstrel sessions. On the day of our visit, the OT was taking a small group of patients to the pantomime.

Visiting is flexible and relatives are encouraged to be involved in meals and activities. We spoke with seven relatives. There was a very strong message that they are made to feel very welcome and feel that staff will always ‘go that extra mile’ to ensure that patients are happy and cared for.

Recommendation 3:

Managers should review the staffing establishment with a view to ensuring that there is a dedicated activity resource within both wards.

The physical environment

There has been considerable remedial work undertaken since our last visit. The patio areas have been developed, with sheltered areas installed. Further work is planned to improve the gardens.

The wards have benefited from the installation of acoustic boards to absorb sound. This has made a significant difference to the noise levels within the wards.

The large nurses' stations have been removed from the central areas, and flooring has been replaced. This has enhanced the space available to patients.

Showers have been adapted to meet the needs of the patient group, with the majority of showers having been changed to removable shower heads which can be hand held by staff. Staff continue to report that the bathroom in North Ward is small and it can be difficult to accommodate patients who require a hoist and the assistance of several staff. However, we are advised this has been assessed and is felt to be adequate from a health and safety perspective and there are adequate disabled shower facilities.

Any other comments

Relatives spoke very positively about the ward staff, and many commented that staff always consult and communicate with them. Visitors told us that they felt welcome within the ward and were confident that their loved one was being well cared for.

Summary of recommendations

1. SCN should ensure that life history is easily accessible within the care file and should be used to inform person centred care.

2. SCN and RMO should ensure that patients receiving covert medication have a completed covert medication pathway in place to ensure that there is an appropriate legal framework for this and that proxies have been consulted.

3. Managers should review the staffing establishment with a view to ensuring that there is a dedicated activity resource within both wards.

Good practice

We were very impressed with the links which were being developed with the local hospice and the focus on enhancing palliative care provision within 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.

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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