Mental Welfare Commission for Scotland

Report on announced visit to: Waverley Unit, Quayside Nursing Home, 250 Halliday Street, Glasgow, G13 4DT

Date of visit: 18 December 2018

Where we visited

Waverley Unit is an NHS-funded unit within Quayside Care Home. It has 24 en-suite single rooms and provides care for residents with a diagnosis of dementia. All of the residents have been placed in the unit because they no longer require acute hospital care. Some will require further placements in care homes, and a few may go home. All of the residents in Waverley unit require welfare guardianship orders. This unit within Quayside is registered as a care home with the Care Inspectorate.

We last visited this service on 6 August 2014 and made recommendations regarding training around the Adults with Incapacity (Scotland) Act 2000 (AWI Act), proxy decision makers and section 47 of the AWI Act, the need to ensure focus remains on patient-centred care, making the environment more dementia friendly, and addressing odours and noise. There were no issues relating to the previous recommendations at this visit.

On the day of this visit we wanted to meet with residents and carers and follow up on our previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of nine residents. We also met with seven carers, relatives, and friends.

We spoke with the nursing home manager, the unit manager, and the area manager.

Commission visitors

Mary Hattie, Nursing Officer,

Anne Buchanan, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

In the files we reviewed, initial assessments were detailed and included information on residents' self-care abilities, as well as their needs. Care plans reflected these assessments, were person centred, reviewed regularly, and contained a good level of detail of residents' preferences and routines.

Where a resident experienced stress or distress, the care plan included information on triggers, where these were known, and detailed individual de-escalation and distraction techniques which were effective. There was clarity about the use of as-required medication and the number of times it could be used before the care plan and prescription had to be reviewed.

Where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place, consultation with relatives was documented. There was no evidence of any proxy decision makers through, for example, power of attorney documents.

The majority of the care files we reviewed did not contain life story information, and in the few which did this was very limited. As most of the residents are likely to move onto further care placements, it is important that this information is written down and follows them through their care journey.

We were advised that there is a monthly multidisciplinary team meeting which is attended by the consultant, GP, social worker, and nursing staff.

Outwith this, the consultant psychiatrist and GP visit the unit twice a week, and the GP can be contacted via the surgery if required. Out-of-hours medical care is provided by NHS 24.

Occupational therapy, physiotherapy, and other allied health professional input such as dietetic services are provided on a referral basis. There are no dedicated allied health professions sessions. Pharmacy input is available when required. Psychology is available on a referral basis, but is rarely used.

The unit has two dementia champions, and all staff have undertaken training to informed level on the NHS Education Scotland Excellence in Practice training programme.

Recommendation 1:

Managers should ensure that life history information is recorded and follows the resident when they move to a further care placement.
https://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report%20Remember%20Still%20Me.pdf

Use of mental health and incapacity legislation

There was no one subject to provisions of the Mental Health (Care & Treatment) (Scotland) Act 2003 within the unit during our visit. No one was subject to guardianship or had a power of attorney in place, although we were advised that all of the residents had a guardianship application in process.

The residents we met with had been assessed as lacking capacity to make decisions about their care and placement, but had been moved from hospital into an NHS-funded care home bed without any legal process to authorise this.

The Commission understands that in many cases it is appropriate, and in the interests of an individual with dementia, to move as quickly as possible from an acute hospital setting to a care environment. However, it is important that patients' legal and human rights are protected in such situations, that their will and preference is fully taken into account, and that there are appropriate opportunities for the patient, their advocate, or

other interested parties to challenge such a move. It is also vital that staff have a clear understanding of the legal status of residents while they are in the home.

We were not persuaded that this is currently the case, and believe the process of placing individuals in these beds needs urgent review to ensure there is appropriate legal authority in place. This is generally good practice, but in as much as these placements may give rise to a deprivation of liberty as defined in the Cheshire West ruling, it is necessary in order to comply with Article 5 of the European Convention on Human Rights.

We are raising our concerns with NHS Greater Glasgow and Clyde, but the care home also has a responsibility to ensure its arrangements are lawful and respect human rights requirements.

Recommendation 2:

Managers should ensure that there is an appropriate legal authority in place to authorise the placement of residents in the home, before accepting admission.

Rights and restrictions

The door to the unit is locked by a keypad. There is no information on display to advise residents or visitors how to exit the building. During our visit no one was actively trying to leave, but were told by staff that there are occasions when residents make it clear they do not wish to stay in the unit and attempt to leave. We discussed with staff how they managed these situations. Whilst staff spoke of being able to manage this by distracting residents on most occasions, there appeared to be limited understanding of the legal position, which is that the residents are informal and therefore may be being deprived of their liberty without legal authority.

None of the residents whose files we reviewed had support from advocacy. On discussing this with the care home manager we were advised that, whilst they had sought advocacy involvement for some residents, advocacy services appeared to be under pressure and considered most of their referrals as low priority. Therefore they did not always get a service. Access to advocacy is particularly important given our concerns about the way residents have been placed in the home, and because the residents are all subject to guardianship proceedings and a future move.

Recommendation 3:

Residents and their relatives should be made aware of the residents' legal status and their rights.

Recommendation 4:

Given the restrictions on residents' freedom without appropriate legal authority, managers should discuss the level of advocacy provision available with the local authority to ensure that residents' right to advocacy is upheld and access prioritised.

Recommendation 5:

There should be a locked door policy in place and information on how to access and exit the building should be clearly displayed.

Activity and occupation

We are advised that there has recently been a reduction in activity provision due to an unfilled vacancy. Currently two activity staff are providing activities across the six units.

We found evidence in care files of residents participating in a variety of activities such as pamper sessions, craft groups, and music sessions, and saw some residents participating in games during our visit.

Waverley Unit has regular visits from Therapet services, and the home has a dog which also visits regularly. Local schools visit periodically, and provide activities such as the recent carol session. There are monthly musical events within the home, which residents from Waverley can attend. Residents can visit a local 543 club monthly. and there are monthly outings in the minibus during the summer months. During our visit the home had reindeer visiting and many of the residents from Waverley Unit were taken to see them.

Activity care plans gave good information on previous hobbies and activity preferences. However, recording of activity participation was limited and it was not always clear how these were being met within the unit.

Recommendation 6:

Managers should ensure there is adequate activity provision to meet the needs of all residents and provide them with a meaningful day.

The physical environment

The unit appeared clean, bright, and free from odours. The large dining/sitting area was pleasantly furnished, and tables were set with condiments and napkins. There were also two small bright quiet sitting areas off the main area. There were seats at a number of points in the corridors to allow residents to stop and rest. Signage throughout the unit was dementia friendly. Corridors were well lit, and furnished with pictures.

There is a pleasant enclosed garden, which is accessible directly from the unit. This is open to residents when the weather allows.

We noted that rooms were personalised with pictures and personal effects. On each bedroom door there were a few lines of information that the individual or their family wished staff to know about them.

Any other comments

Patients have a responsibility to inform the relevant benefit office when they go into or out of hospital. Given the ambiguity of the status of the Waverley Unit, it is important that residents and their relatives are clear as to their responsibilities and have clarity regarding their status. There could also be implications for residents in relation to entitlement and housing benefit payments.

Recommendation 7:

Managers should ensure residents are fully informed of their status in relation to benefits, allowances, and pension provisions.

Summary of recommendations

1. Managers should ensure that life history information is recorded and follows the resident when they move to a further care placement. https://www.mwcscot.org.uk/media/53179/CC__MWC_joint_report%20Remember%20Still%20Me.pdf

2. Managers should ensure that there is an appropriate legal authority in place to authorise the placement of residents in the home, before accepting admission.

3. Residents and their relatives should be made aware of the residents' legal status and their rights.

4. Given the restrictions on residents' freedom without appropriate legal authority, managers should discuss the level of advocacy provision available with the local authority to ensure that residents' right to advocacy is upheld and access prioritised.

5. There should be a locked door policy in place and information on how to access and exit the building should be clearly displayed.

6. Managers should ensure there is adequate activity provision to meet the needs of all residents and provide them with a meaningful day.

7. Managers should ensure residents are fully informed of their status in relation to benefits, allowances, and pension provisions.

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 The Care Inspectorate

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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