Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 24, University Hospital Monklands, Monkscourt Avenue, Airdrie, ML6 0JS

Date of visit: 18 October 2018

Where we visited

Ward 24, the North Lanarkshire Specialist Dementia Complex Care Unit, is a 20-bedded mixed-sex ward for assessment of older people with a form of dementia, specifically focussing on stress and distressed behaviours. The ward is situated on the lower level of a large district general hospital. There are five single rooms and five three-bedded dormitories as well as a lounge, a dining area, an activity space and a relaxation area. There is also an enclosed garden area that can be accessed from the ward.

The ward multidisciplinary team consists of six consultant psychiatrists, junior medical staff, nursing staff, occupational therapy, psychology, pharmacy, and dietetics. Other disciplines and social work are accessed as required.

When we visited there were 11 patients on the ward, one of whom was detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA).

We last visited this service on 4 July 2016, when it was located at University Hospital Wishaw, and made recommendations in regard to care plans.

On the day of this visit we wanted to follow up on the previous recommendations and to look at how the staff ensure patient privacy and dignity. We also wanted to look at staffing and safety issues that had been brought to our attention by relatives relating to the previous ward site. We also wanted to hear how the ward had coped with the move from the previous hospital site.

Who we met with

We met with and/or reviewed the care and treatment of six patients. As this was an unannounced visit, relatives had not been informed of the visit so were not available on the day of the visit.

We spoke with the senior charge nurse (SCN), one of the charge nurses, staff nurses, and the discharge co-ordinator.

Patients spoken with were complimentary about staff and the care they are receiving.

Commission visitors

Margo Fyfe, Nursing Officer

Yvonne Bennett, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We were pleased to see that multidisciplinary review notes were clear, and that the new system of recording these to show both nursing and medical views was in use. However, it would be good to see clearer forward plans included to show progress and, where appropriate, discharge plans. We also saw clear notes from occupational therapy input to patient care within the electronic record system.

The ward used the Newcastle Model for stressed and distressed behaviours. This was supervised by the Band 6 nurses who receive supervision sessions from the psychologist who had two sessions per week in the ward. They also carried out staff training in this area of care.

There was regular pharmacy input around audits of medication use, in line with the Scottish Patient Safety Programme.

We were also pleased to hear about the delayed discharge process in place. We had an opportunity to speak with the nurse who held the delayed discharge liaison role. He described the process now in place, along with the multi-agency working that underpins the process. The longest delay on the ward was due to awaiting a welfare guardianship to be put in place. This should be resolved soon, as the hearing date has been set.

Nursing documentation and care plans

Nursing notes were written on the 'situation, background, assessment, review' (SBAR) model, which ensured that there was continuity in notes, and reflection on the patients' progress throughout the day. While notes were informative, we discussed with the SCN the importance of describing overarching statements to ensure clarity of meaning for anyone reading the notes.

When we last visited, we had highlighted the need for changes in the way the care plans were written and how they linked to the multidisciplinary notes. We were aware that senior staff had changed and that care plans were being worked on. On this occasion, although care plans are now more person centred, we found reviews to be inconsistent and lacking in detail. We also found that the care plans would benefit from being separated out to define physical and mental health care needs. In discussion with the SCN, we suggested that having care plans in place that looked at the patient as a whole would enable them to include social issues that may be having a detrimental effect on mental health. We recommend that this is addressed urgently to ensure best practice and benefit to patients.

Recommendation 1:

Managers should ensure medical and nursing staff are fully aware of how to complete multidisciplinary review notes on the electronic system and that this includes clear forward plans for the individual patients.

Recommendation 2:

Managers and the SCN should audit care plans and reviews to ensure they accurately reflect patient health care needs and progress in line with multidisciplinary reviews.

Use of mental health and incapacity legislation

We found all consent to treatment documentation to be up to date and in place where required.

There were no patients on the ward with guardianship under the Adults with Incapacity (Scotland) Act 2000, but there was paperwork there when this was in process. We were also informed that a few patients had a welfare power of attorney in place to allow a relative to make decisions on their behalf. However, we could not locate paperwork to confirm this, and discussed with the SCN the need to obtain the documentation to confirm this is in place.

Rights and restrictions

The ward had a locked main door for patient safety. There was a policy in place and patients and relatives were informed of the need for the locked door on admission.

Patients could access the garden, weather permitting. There were staff present when the garden was in use to ensure patient safety.

Prior to the visit we had heard from relatives of previous patients that there were concerns regarding the privacy and dignity of patients prior to the ward moving hospital sites. We were pleased to see that, when patients are in single rooms, these are locked when they are not in their rooms to ensure safety of their belongings, and staff are around the area of dormitories to ensure only patients allocated to dormitories are in them. We also heard of plans to ensure the environment is made more dementia specific, which will also address privacy and dignity. We look forward to seeing these environmental improvements at future visits.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

This can be found at https://www.mwcscot.org.uk/rights-in-mind/

Activity and occupation

During the visit we saw staff spending time with individual patients participating in meaningful activity.

The ward used to have an activity co-ordinator who has now retired. We understand that at present there is no plan to have an activity co-ordinator. Whilst this is manageable with lower patient numbers, we wonder if this may be more difficult to manage with a full patient complement. We suggest that this is closely monitored. They now use the Jackie Pool model to assess individuals' abilities and interests in regard to activities. clinical support workers were trained in the use of this model, and documentation held in a separate folder is clear. We found activity participation notes were detailed in daily nursing notes, with no general indication where to locate this information. We suggested that a note is held within the paperlite file of when activity participation has occurred, for ease of reference.

Occupational therapy staff carried out group activities as well as individual activities, and these were documented under their discipline on the electronic record system.

The physical environment

The ward was bright, and had space for patients to sit and to rest in the corridor as well as several communal rooms. We heard from the SCN about planning in place to ensure the environment is specifically dementia friendly, in line with the national dementia standards. We look forward to seeing these changes at future visits.

We also heard about efforts of a previous patient's family to fundraise for a family room to be put in place on the ward, and that several other families had donated to the project. This will allow family, where needed, to remain with a terminally ill patient and also have a small space for themselves at a difficult time in their lives. We also look forward to seeing this at future visits to the ward.

There was an enclosed garden space specifically for Ward 24 patients. There were several seating areas and raised bedding plant areas. The entrance to this space is to be changed to a more accessible area in the ward. Patients were encouraged to use this space, weather permitting.

Any other comments

Although the ward had empty beds, we are aware that this will not always be the case. As the ward is on a general hospital site there may be bed pressures in the other areas of the hospital from time to time. However, in order to build a specialist service within the ward, it is important that the beds are used for their specific remit around dementia with behavioural issues. We were pleased to hear that nursing vacancies are being filled and that there is a lower use of bank staff. This allows continuity of care and familiarity for patients.

Summary of recommendations

1. Managers should ensure medical and nursing staff are fully aware of how to complete multidisciplinary review notes on the electronic system and that this includes clear forward plans for the individual patients.

2. Managers and senior charge nurse should audit care plans and reviews to ensure they accurately reflect patient health care needs and progress in line with multidisciplinary reviews.

Good practice

During admission to the ward relatives are encouraged to participate in the care of the patient where they and the patient want this to continue. On admission, relatives are given information on ward routines and meetings which they are encouraged to attend.

There is a monthly carers' group that focuses on the carers' needs. This is run between the carers' network and ward staff. We were pleased to hear that the group covers North and South Lanarkshire, as not all relatives/carers will live in the same area as the 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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