Mental Welfare Commission for Scotland

Report on unannounced visit to: Midlothian Community Hospital, Glenlee Ward, 70 Eskbank Road, Dalkeith EH22 3ND

Date of visit: 12 January 2017

Where we visited

Glenlee is a 20 bedded continuing care ward for patients who are over 65. All patients on the ward have a mental health problem, most of whom have a dementia diagnosis and can exhibit stressed and distressed behaviour. We last visited the ward on 8 December 2015 and made recommendations regarding care plans, multidisciplinary team (MDT) recordings and documentation in relation to the Adults with Incapacity (Scotland) Act 2000 (AWI).

On the day of this unannounced visit we wanted to follow up on the previous recommendations. On the day of the visit the ward was full.

Who we met with

We met with and reviewed the care and treatment of eight patients. We also met with three relatives and two staff nurses on the ward. We met with the clinical nurse manager and the chief nurse at the end of the visit to discuss our findings.

Commission visitors

Moira Healy, Social Work Officer

Margo Fyfe, Nursing Officer.

What people told us and what we found

Care, treatment, support and participation

The individuals we met with or observed appeared to be well looked after, and for those people who could talk to us about their care and support, they told us that they were happy with the support provided by staff. The three relatives we met with were also complimentary about the care their relatives had received and the support they had been given.

From the files we examined, personal history profiles were generally of a high standard.

We were told by relatives and the staff that in the past year a number of nursing staff had either moved on or were about to move on to different posts. This had resulted in the ward undergoing an unsettled period.

We took the opportunity to look at care plans, daily progress notes, weekly ward round notes and MDT review notes.

Notes were well organised and easy to navigate, however we were disappointed to see that the improvements in the care plans which had been made in 2015 had not been upheld throughout 2016. Care plans we read on the day did not have clear goals or specific interventions which related to each individual. Mental health care plans in particular could have been more comprehensive and person-centred. Reviews were not always meaningfully evaluated and given the significant improvement that had been made in 2015 we felt this was inconsistent and would like an immediate review of the care planning documentation and to be informed of the progress on this.

Recommendation 1:

The ward manager and clinical nurse manager should conduct an audit of all care plans and reviews to make sure they are person-centred, individualised and describe specific interventions in relation to the management of behaviour.

MDT reviews

Whilst we were aware of the high level of multidisciplinary input to the ward, we found the evidence of MDT meetings to be poorly recorded. The new MDT recording sheets were not always well used, which was disappointing, as part of this process would mean goals would be evaluated meaningfully and care plans changed. The MDT document should demonstrate an awareness of that person's progress whilst they are on the ward. In addition to this, some of the MDT meetings were not always held at intervals appropriate to this client group.

Recommendation 2:

Managers should audit all MDT paperwork and ensure all paperwork is completed appropriately, in detail and in accordance with that person's needs.

Pharmacy input to this ward, particularly in relation to initial advice regarding covert medication, is of a high standard, however the regular reviews do not appear to have taken place. The clinical nurse manager was informed of this on the day of the visit and agreed to follow up.

Physical health care plans were of a high standard.

Use of mental health and incapacity legislation – AWI Act welfare proxies

In most of the case files we reviewed, where there was a welfare proxy (guardian or power of attorney) the powers were in place. However, details had not been fully recorded even though the legal documents had been obtained.

We suggested the use of the Mental Welfare Commission checklist for ease of ensuring that the guardianship details have been discussed with the guardian or welfare proxy, and that the checklist can be found on our website.

http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf

Recommendation 3:

Managers should ensure all AWI guardianship and power of attorney documents are discussed with those proxies and in consultation with them, and delegation of those powers as appropriate has been recorded appropriately.

Section 47 (s47) proof of incapacity certificates

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 of the AWI Act must be completed by a doctor. It must cover all relevant treatment that the individual is receiving. Unfortunately we found that the s47 certificate paperwork was inconsistent. At times this was generic and other times included conditions that the individual did not have. Physical health care plans were of a high standard and included the conditions that that person may need help with or medication for. It was disappointing that this was not reflected in the s47 certificate paperwork.

Recommendation 4:

Managers should ensure that all people who lack capacity to consent to their medical treatment should have a comprehensive s47 certificate in place and either a treatment plan attached or note of their individual medical conditions included within the certificate itself.

Consent to treatment

Part 16 (Section 235-248 of the Mental Health Act) sets out the conditions under which treatment may be given to detain patients. The forms used by the responsible medical officer (RMO) to record consent to treatment certificate (T2) or certificate authorising treatment (T3) must also record a care plan of treatment. Ward T2/T3 forms were completed as appropriate and could be located within the medication charts.

Covert medication

When a patient is in receipt of covert medication, we recommend that each illness should be included on the s47 certificate and that a copy of the s47 certificate treatment plan and covert medication pathway be stored with the drug prescription sheet.

In all but one occasion, covert medication pathways were present as required and properly authorised. There was evidence of clear consultation with the pharmacist attached to the ward.

Activity and occupation

We were told by three of the patients we met that they were bored whilst on the ward, and this gave us cause for concern. There has been a change in activity co-ordinator and the new person took up post in December 2016. We were assured that activities were not seen as the sole responsibility of the activity co-ordinator. Unfortunately on the day of this visit we were unaware of healthcare assistants becoming involved in activities, which was different from the last visit, when they were involved. We saw good examples of activities within the notes, and we were also able to see that within the last year there was an imaginative use of the resources they had to hand. An occupational therapist (OT) and OT assistant also have input to the ward.

The lack of patient engagement in activities on the ward on the day of the visit was disappointing as this was something that was clearly promoted during last year's visit. It is good to see that the new activity co-ordinator is in post, and we would hope that her enthusiasm will instil confidence amongst the staff on the ward to be more involved in activities. Activities undertaken by the activities co-ordinator and OT assistant were person-centred and well recorded.

The physical environment

Improvements to the environment made since the 2014 visit were still in evidence, and the environment had been improved further by the introduction of two fireplaces in the lounge area of the general communal area and within the reminiscence room. One relative in particular commented on how helpful this has been by providing a warm focus for both of those rooms, and they certainly seemed to be enjoyed by the patients on the day.

Summary of recommendations

Recommendation 1:

1. The ward manager and clinical nurse manager should conduct an audit of all care plans and reviews to make sure they are person-centred, individualised and describes specific interventions in relation to the management of behaviour.

2. Managers should audit all MDT paperwork and ensure all paperwork is completed appropriately, in detail and in accordance with that person's needs**.**

3. Managers should ensure all AWI guardianship and power of attorney documents are discussed with those proxies and in consultation with them and delegation of those powers, as appropriate, have been recorded

4. Managers should ensure that all people who lack capacity to consent to their medical treatment should have a comprehensive s47 certificate in place and either a treatment plan attached or note of their individual medical conditions included within the certificate itself.

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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