Mental Welfare Commission for Scotland

Report on unannounced visit to: Maple Villa, Larch Grove, Livingston EH54 5BU

Date of visit: 13 November 2017

Where we visited

Maple Villa is a 25-bedded NHS continuing care unit for males aged over 65 with dementia and who require complex nursing care (often due to stressed and distressed behaviour). Each individual had a single en-suite bedroom with TV. The unit was built as a specialist dementia unit.

There were 24 patients in the ward on the day of our visit.

We last visited this service on 9 January 2015 and made recommendations in relation to activities, the use of legislation, care planning, risk assessment and medication.

Who we met with

We met with four patients, and reviewed the care and treatment of seven patients and met with one carer.

We spoke with the newly appointed senior charge nurse, the deputy charge nurse, staff nurses and the activities coordinator.

Commission visitors

Susan Tait, Nursing Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Patients seemed comfortable in the ward and in the company of staff. Throughout our visit we saw staff interacting warmly with patients, responding quickly when they required assistance, and treating them in a respectful, caring manner. Staff were knowledgeable about people as individuals when we spoke to them.

A good culture was evident within the staff team, focussed on delivering person-centred care, developing good practice and involving and supporting relatives. Staff seemed positive and motivated.

In the last report, we made a recommendation that care plans address all identified risks for patients, and reflected care to manage these risks. This was still not evident in files we reviewed. There were also care plans, which seemed unnecessary, covering all aspects of activities of daily living when there had been no identified need. The senior charge nurse acknowledged this and was aware that this needs to be addressed. As this had been raised in the last report in 2015, it is concerning that the recommendation had not been actioned. We did see two care plans that had been completed by staff from the management of stressed and distressed behaviour team. These were exemplary and could be used to inform further planning for other patients.

The files we looked at were disorganised, with an excess of historical information in them.

Recommendation 1:

Senior nurse should arrange for audit of all care plans to ensure that they reflect the care required, including removing all unnecessary information. They should include regular meaningful reviews.

Use of mental health and incapacity legislation

Most of files we reviewed had certificates of incapacity (s47) under the Adults with Incapacity Act in place. There were issues with some s47 certificates/treatment plans seen. Two s47 certificates did not detail treatment that was prescribed.

Link to Code of Practice for Part 5 of the AWIA:
http://www.scotland.gov.uk/Publications/2010/10/20153801/0

This issue had been raised in the previous report.

Where patients had a Power of Attorney in place, this was not always identified in the information sheet in the notes, and was not always in evidence. It is important to have a copy of the powers in the file.

Recommendation 2:

Managers should ensure that s47 certificates and treatment plans, if required, are completed in accordance with the code of practice, and cover all medical treatment the patient is receiving that they are not capable of consenting to.

Rights and restrictions

Maple Villa has a locked door for the protection of vulnerable adults. The locked door policy was not displayed and when it was located in a folder, the policy was not being followed. It stated that all patients should be risk assessed to determine whether they met the criteria whereby they required a locked door to ensure their safety and this had not happened.

Recommendation 3:

The senior nurse should ensure that the locked door policy is reviewed, clearly displayed and adhered to.

Prescriptions for 'if required' psychotropic medications

We saw some prescriptions for "as required" psychotropic medications that included intra muscular injections (IM) for stressed and distressed behaviour/agitation which had been written by the GP, for patients who were not detained. If an individual in hospital requires restraint as treatment for mental disorder, a doctor should assess them and consider possible need for detention under the Mental Health Act. If there is frequent need for restraint, consideration should be given to detention under the Mental Health Act to provide legislative authority for this.

In the last report, there were concerns raised about interval timings for 'as required' medication, which had been resolved.

Recommendation 4:

The senior nurse should arrange for the GP to review the practice of prescribing IM medication for informal patients to ensure that patients' rights are respected.

Activity and occupation

There are two activities coordinators in Maple Villa who provide 20 hours one week then 40 hours the next. This has been an increase since the last visit.

There is a monthly 'chippy night', a concert once per month and other seasonal activities.

Patients had activities care plans. There were entries in their notes of engagement in group and one-to-one activities such as newspaper groups, music, ball games, drawing, seasonal parties, reading magazines and looking at photos with staff, etc.

The physical environment

The environment was clean, bright, pleasant, and fit for purpose. Individual bedrooms all had TVs and were ensuite. Some bedrooms were well personalised.

There was dementia friendly signage e.g. on some individuals' bedroom doors, and for the dining room and sitting room. The large paintings on toilet doors were particularly good and clear. Toilets were dementia friendly.

There were some interesting pictures and themed murals on the walls. There was a wall mounted board with locks and chains in the corridor, which is a good point of interest/activity. However, the public areas of the ward were rather clinical and stark, and there were not a lot of items of interest around, such as rummage boxes. The murals have been in place for some years now and include representations of real life objects, such as a door which was painted as a phone box. This can be confusing for people with dementia and should be reviewed.

There was a very nice, bright family room with coffee making facilities and a piano. This can be used by individuals with their families and booked for family events. It is used for activities during the day. It is locked when not in use for these purposes.

There was access from a seating area to a central enclosed courtyard garden. This was dementia friendly, with benches and raised garden beds.

Any other comments

The relatives we met on the day of the visit were very complimentary about the care provided and that communication with staff was very good.

Summary of recommendations

1. Senior nurse should arrange for audit of all care plans to ensure that they reflect the care required, including removing all unnecessary information. They should include regular meaningful reviews.

2. Senior nursing and medical staff should ensure that s47 certificates/treatment plans are completed in accordance with the code of practice, and cover all medical treatment the individual is receiving that they are not capable of consenting to.

3. The senior nurse should ensure that the locked door policy is reviewed, clearly displayed and adhered to.

4. The senior nurse should arrange for the GP to review the practice of prescribing IM medication for informal patients to ensure that patients' rights are respected.

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 Thomson
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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