Mental Welfare Commission for Scotland

Report on unannounced visit to: Wallace Hospital, 119 Americanmuir Road, Dundee DD3 9AG

Date of visit: 15 August 2017

Where we visited

Wallace Hospital is an independent hospital providing assessment and treatment for adults who have a learning disability and complex needs. Wallace Hospital is currently registered for ten adults.

We last visited this service on 10 August 2016 and made recommendations about care planning and about consultation with guardians about treatment decisions. At the time of that visit the building, which was previously Monroe House, was in the process of being divided into two separate units, with the top floor to be registered as an independent hospital and the ground floor to be registered as a care home for adults with a learning disability. A considerable amount of building work was taking place on the day of our visit but this work has now been completed. The building now has two separate units, with Wallace Hospital being registered and inspected by Healthcare Improvement Scotland and Thistle Care Home registered and inspected by the Care Inspectorate. This unannounced visit was to Wallace Hospital.

Because building work was underway at the time of our last visit there were very few patients in the hospital unit.

On the day of this visit we wanted to look generally at how care and treatment was being provided following all the changes which had taken place. We also arranged for this unannounced visit to be undertaken on the same day that Healthcare Improvement Scotland were visiting Wallace Hospital, so that there was a shared approach to reviewing care and treatment within the service.

Who we met with

We met with and reviewed the care and treatment of three patients during the visit.

We spoke with the service manager, the senior nurse on duty and the occupational therapist (OT) who works within the service. In addition we met with the nurse consultant who provides input to all the service provider units in Scotland and who happened to be in Wallace Hospital on the day we visited.

Commission visitors

Ian Cairns, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Care planning

On our last visit we found that care plans were person-centred and comprehensive and were being reviewed regularly at multi-disciplinary team (MDT) meetings and at care programme approach (CPA) meetings. This was still the case and MDT and

CPA meetings were generally well recorded, with detailed reports from MDT members being prepared for CPA meetings. We also noted on our last visit that care planning documentation was cumbersome and complex and with a great deal of information in different files for each patient and this was difficult to follow.

On this visit we found care planning documentation was still bulky and complicated. We also felt that some plans could have more specific details and could identify care plan goals more explicitly. As an example a report for one CPA meeting referred to developing daily living skills, and staff could describe how this task was being progressed with the individual patient. However, the care plan had few details about specific care and support interventions relating to developing living skills with this specific patient.

We also saw on files that risk assessments were in place, were being reviewed and had an appropriate focus on primary, secondary and tertiary strategies (interventions used by staff to reduce and manage any risks patients may present to themselves or others). We noted though that risk management plans at times could have been more detailed, and that plans could refer to using approaches such as de-escalation strategies, with specific information about the known de-escalation strategies which staff have found work with an individual patient.

Recommendation 1:

Ward managers should review care planning processes looking at where documentation can be simplified and whether individual care plans are appropriately recording specific interventions and care goals.

Participation

On our last visit we saw that good attention was being paid by staff and particularly by the speech and language therapist (SALT), to enhance communication between staff and patients and enhance the participation of patients in decisions about their care and treatment.

We saw detailed communication passports on this visit. However, we were also made aware that the SALT post in the hospital has been vacant for a number of months now. This post is now in the process of being filled but the lack of SALT input has meant that work to develop individual communication strategies for individual patients has been delayed.

We were pleased to see that there is advocacy input in the hospital and this does seem to help patients feel they are participating in care planning which was confirmed by comments we heard from one patient.

Use of mental health and incapacity legislation

Mental Health Act (MHA) paperwork was well maintained in individual files. We reviewed a number of medication prescriptions, which all complied with consent to treatment requirements under the MHA.

Certificates should be completed under s47 of the Adults with Incapacity Act (AWI) where an individual lacks capacity in relation to decisions about the medical treatment. On our last visit we noted that doctors who completed s47 certificates did not always seem to be discussing medical treatment with the nominated guardian when patients were subject to guardianship orders and the guardian had the specific power to consent to medical treatment. On this visit we did see that s47 certificates which had been completed since our previous visit did record discussions with guardians.

Rights and restrictions

We found in one case that a patient was having restricted access to their mobile phone. Sections 281-286 of the MHA provide a framework where restrictions can be placed on people who are detained in hospital and the patient must be a specified person in relation to these sections of the Act when restrictions are in place. In one case a detailed care plan was in place for the patient's use of their mobile phone but the relevant form which a psychiatrist should complete when they make someone a specified person was not on file and had not been sent to the Commission. This was discussed with staff on the day, with follow-up phone contact to the unit.

Recommendation 2:

Managers should ensure that the responsible medical officer (RMO) implements specified persons' procedures and completes relevant forms to authorise specific restrictions.

Activity and occupation

We saw good examples of individualised activity timetables and we saw that patients are accessing activities in the community. Wallace Hospital is on the upper floor of the building and patients do not have access to a designated garden area. This can mean that if a patient is not going to an activity in the community they have little opportunity to access outside areas.

Recommendation 3:

Managers should review the access that patients can have to outside areas outwith any planned community based activities.

The physical environment

Refurbishments in the building have now been completed and Wallace Hospital is based on the upper floor of the building. It has seven single bedrooms with three self-contained living apartments for couples. As a result of the refurbishments there are improved facilities for patients in the hospital, with a large kitchen available to support people to develop independent living skills and with good spacious communal lounge areas. There is no designated garden area though which patients can access easily (see recommendation relating to activity and occupation).

Summary of recommendations

1. Managers should review care planning processes and looking at where documentation can be simplified and at whether individual care plans are appropriately recording specific interventions and care goals.

2. Managers should ensure that the RMO implements specified persons' procedures and completes relevant forms to authorise specific restrictions.

3. Managers should review the access that patients can have to outside areas outwith any planned community based activities.

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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