Mental Welfare Commission for Scotland

Report on announced visit to: Rowan and Willow Units, Stracathro Hospital, Brechin, DD9 7QA

Date of visit: 25 June 2018

Where we visited

Rowan and Willow Units are old-age psychiatry units at Stracathro Hospital. Rowan Unit is a mixed-sex unit with 15 beds providing admission, assessment and treatment for older people with functional mental health problems. Willow Unit is a mixed-sex unit with 12 beds. This unit provides admission, assessment and treatment for people with dementia as well as short-term and intermediate care to people with dementia who are experiencing agitated or distressed behaviours.

We last visited this service on 24 May 2017. We made recommendations about collecting life story information about the patients, and about some refurbishment work required. We received an appropriate response to these recommendations, with an action plan which listed actions taken and told us that planned actions had either been completed or gave us an update on progress if actions were still ongoing.

On the day of this visit we wanted to look generally at the care and treatment being provided in the wards.

Who we met with

We met with and/or reviewed the care and treatment of 17 patients and spoke with two relatives.

We spoke with the service manager, charge nurses and other members of staff in the two wards, and the consultant psychiatrist for these wards.

Commission visitors

Ian Cairns, Social Work Officer

Douglas Seath, Nursing Officer

Dr Natalie Jeffrey, Temporary Medical Officer

What people told us and what we found

Care, treatment, support and participation

In the majority of cases we reviewed we were not able to have meaningful conversations with the patients because of the progression of their illness. In these cases we reviewed their files. Where we were able to speak with patients they were positive about the care and treatment provided in the wards. We observed positive and supportive interactions between nursing staff and individuals in the wards during our visit. The relatives we met also spoke highly about the care and treatment they observed on visiting the wards, and said that they felt that staff kept them well informed about the care and treatment being provided.

Care planning documentation

The files we reviewed on the visit were all well-organised and well-maintained. The index at the front of the files made it easy to find information. Care plans were of a good standard, with appropriate risk assessments and risk management plans evident in files. Care plans were person-centred, identifying individual needs and clearly recording any changes in needs and in planned interventions. Care plans also seemed to be regularly reviewed, evaluated, and updated as appropriate.

The multi-disciplinary team meetings held in both units are well recorded. We could see from this information who participates in meetings, and what specific decisions are made at these meetings. It was clear from the file reviews that good attention is paid to physical health needs, with liaison and input as appropriate from other medical specialists. It was also clear in reviewing files that there is good input from allied health professionals in the wards, with pharmacy profiles in files, occupational therapy (OT) assessments completed and OT input recorded. There was also clear input from speech and language therapy services, for example to produce guidelines on safe swallowing.

We did see 'Getting to know me' forms in files. We feel that these documents, which record a patient's needs, likes and dislikes, personal preferences, and background will help ward staff provide more person centred care during a hospital stay. Some of the forms we saw were very rich and detailed, providing a lot of information which would help staff understand more about a person. We did see some forms which had not been completed, but we understand that staff are very dependent on family members filling in these forms. We recognise that staff do encourage relatives to complete these forms.

Use of mental health and incapacity legislation

Where an individual lacks capacity in relation to decisions about medical treatment a certificate is completed by a doctor under Section 47 of the Adults with Incapacity (Scotland) 2000 (AWI) legislation. A certificate is required by law and provides evidence that treatment complies with the principles of the Act. We saw that s47 certificates were in place in the files reviewed. We had a discussion at the end of the visit about treatment plans associated with s47 certificates, where we were asked to clarify the Commission's view about treatment plans. We have referred the service to the recent good practice guidance reviewed and updated by the Commission in March 2017 *The AWI act in general hospitals and care homes*[1]. This guidance clearly sets out the Commission's view about the use of treatment plans.

We saw do not attempt cardiopulmonary resuscitation (DNACPR) forms in files, and where DNACPR forms were in place we saw evidence of discussion and consultation with families. We were also pleased to see that, where medication was being

[1] https://www.mwcscot.org.uk/media/339351/awi_in_general_hospitals_and_care_homes.pdf

administered covertly, a covert medication pathway was in place and that these pathways were completed fully.

Paperwork relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) continues to be well organised and maintained in files, where patients are subject to compulsory measures under legislation. Medication administered was also authorised appropriately by certificates consenting to treatment (T2) or certificates authorising treatment (T3) where people were detained under MHA. We did notice that in one case medication to be administered for agitation "as required" did not have a maximum dose written in the drug prescription sheet. In another case a T3 form was in place, but a copy was not filed with the drug prescription sheet. These issues were mentioned at the end of visit meeting.

Rights and restrictions

We noticed that patients in the wards seemed to have good access to independent advocacy services, and in several files it was recorded that the patient had been seen by an advocate.

We reviewed in detail the care and treatment being provided to one patient who can display very stressed and distressed behaviours. We found the care and treatment was consistent with the principles in the MHA, in particular with the principles of the minimum restriction on the freedom of the patients and providing the maximum benefit to patients.

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

We felt that in both units there was evidence of good activity provision. There is good OT input, and the supported recovery and therapy service (STARS) also provides input to the units. There is also voluntary sector input into the wards from the local league of friends and from Moonshiners—a group which comes in to provide musical entertainment.

The physical environment

The physical environment in the wards is good, with all accommodation in both units in single en-suite rooms. Windows can now be opened in sitting and dining areas so that fresh air is getting into communal rooms. Both units have good access to sheltered and secure garden areas which are easily accessible. Some remedial work has been completed in the garden areas but some issues do remain outstanding, and there is

ongoing discussion between the service manager and the grounds manager to get this work completed.

Recommendation 1:

The relevant managers should ensure that issues being raised by the service about repair work in the gardens which needs to be completed is taken forward with whoever is responsible for ground maintenance.

Summary of recommendations

1. The relevant managers should ensure that issues being raised by the service about repair work in the gardens which needs to be completed is taken forward with whoever is responsible for ground maintenance.

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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