mentalwelfare commission for scotland

FOCUSSED VISITS 2013

SUMMARY OF RECOMMENDATIONS AND OUTCOMES FROM FOCUSSED VISITS 2013

Summary of outcomes from our focussed visits 2013

The Mental Welfare Commission for Scotland has the duty to visit individuals with mental illness, learning disability and related conditions. This includes visiting people who are receiving care in certain types of facilities e.g. hospitals, care homes and prisons. We visit in order to:

- Allow individuals to tell us about their concerns.
- Assess whether the requirements of legislation are being met.
- Assess the facilities for individuals' care.

One way of achieving this is by what we call focussed visits to particular services or facilities. We undertake focussed visits for various reasons. Some facilities, for example secure units, are more restrictive on individuals' freedom, and we visit them more often as a consequence. In other cases, we may undertake focussed visits in response to concerns we have received or have expressed on previous visits. We will also visit if it has been some time since we were last in the facility. Our focus on the visits will depend on the type of facility and the concerns we have.

Between January 2013 and December 2013 we carried out 98 focussed visits to 96 different services (we visited two services twice). In some hospitals the focussed visit would be to more than one ward but counted as one visit.

We made 339 recommendations relating to these visits.

Following our recommendations, we allow the service three months to formally write to us with their response. If the recommendation is particularly serious and urgent we will reduce the response time accordingly.

Once we receive the response, it is allocated to the Commission officer who coordinated the visit and wrote the visit report to decide if the response is adequate or if we need further information. We further check on any future visits to see that the recommendations were implemented.

This visit year we committed to undertake follow-up action on 90% of our recommendations. This means that we expect compliance with at least 90% of the recommendations we make. We follow-up formally with all services visited to make sure they take appropriate action in response to our recommendations.

In 2013, we were satisfied that services had responded fully to 91% of our recommendations.

We considered that services had made progress on a further 3% of recommendations but further information was required, and these have not been fully implemented yet.

We escalated six recommendations relating to one service as we were not satisfied with the service response. In response to this, we visited the service again to discuss further with the local managers. Our Chief Executive was involved in that visit. We continue to liaise with the service.

We have not yet received responses to 4% of recommendations but are following these up with the services concerned.

We believe this demonstrates our effectiveness in influencing service improvements through a targeted, risked-based programme of focussed visits.

Looking closely at the recommendations we make to particular types of services helps us to determine our future visiting priorities, and what we need to focus on during our visits. It also helps us to determine if we need to carry out a particular themed visit – where we visit a number of services that are for one particular group, or that specialise in one service area – or develop good practice guidance.

Copies of all our visit reports are sent to the Care Inspectorate for visits to care homes, and to Healthcare Improvement Scotland (HIS) for NHS services and private hospitals. Copies of our reports to prisons are sent to HIS and Her Majesty's Inspectorate of Prisons.

We want to make sure that these organisations are aware of any concerns that we have raised as they may choose to look further at these.

This report identifies the main issues raised following our focussed visits and then looks at where we were most likely to make those recommendations. We also give some specific examples of where improvements have been made and which may be of interest to other services across Scotland.

Where we visited

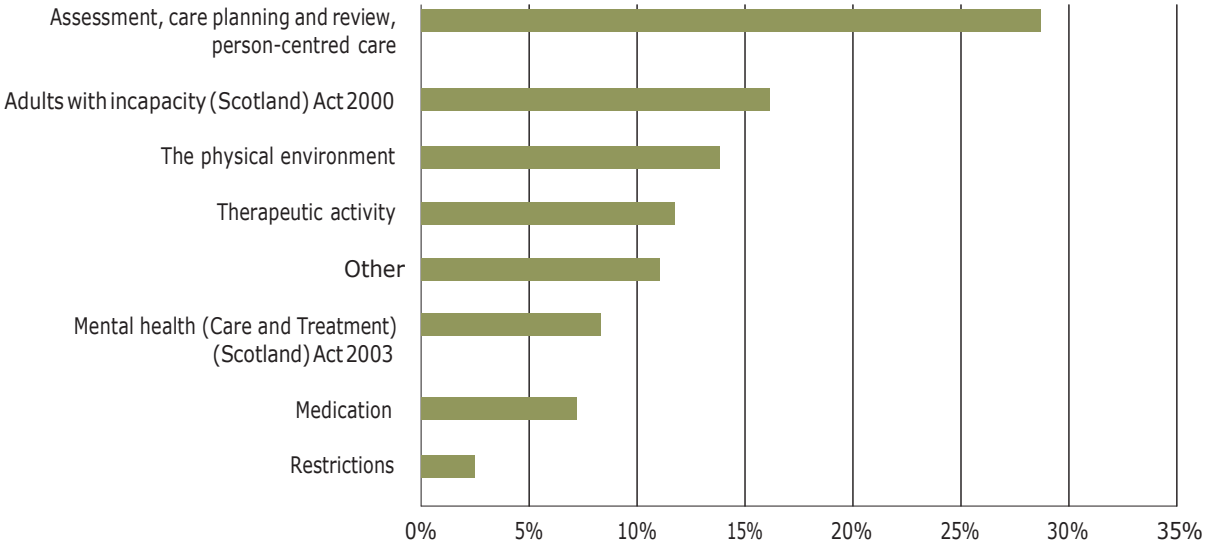
Service Type	Number of services visited		Number of recommendations made	
	No.	%	No.	%
NHS wards adult mental health	15	16	58	17
NHS mental health wards for older people	17	17	64	19
Care homes for older people	22	23	94	28
NHS forensic psychiatry wards	9	9	17	5
Private hospital forensic psychiatry wards	3	3	6	2
NHS wards for people with learning disability	7	7	22	6
Care homes for people with learning disability	7	7	16	5
Prisons	4	4	8	2
NHS ward adult rehabilitation/continuing care	9	9	29	9
Private care provider/care home for adult ehabilitation/continuing care	2	2	8	2
NHS ward for young people/mental health	1	1	3	1
Private care provider/acquired brain injury service	1	1	9	3
Private care provider/alcohol related brain damage service	1	1	5	1
	98	100%	339	100%

Services for older people are the largest grouping and represent the bulk (46%) of visits; they also generated the majority of recommendations over the visit period 2013-14.

What we made recommendations about

These are grouped into the following categories:

- Assessment, care planning and review, person-centred care
- Adults with Incapacity (Scotland) Act 2000
- The physical environment
- Therapeutic activity
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Medication
- Restrictions



Assessment, care planning, review and person-centred care:

Service type	Number of recommendations.	%
Older people (private)	29	30
Older people (NHS)	18	19
NHS adult acute wards	14	14
Other services	36	37
All services	97	100

Ninety-seven of the recommendations we made related to assessment, care planning, review and person-centred care. These recommendations have been combined for the purpose of this report as they can sometimes be difficult to separate out. Of these recommendations, the majority (43 out of 97) related to services for older people in both NHS and private care homes.

Twenty-six of the recommendations related to the provision of person-centred care specifically. By person-centred care we mean providing care that is responsive to individuals' personal preferences, needs and values. In relation to older people, this is the term that we find is most commonly used and understood, but in mental health services or in relation to mental health, recovery is often used.

Some examples of our recommendations and outcomes

We recommended	The service responded
The manager should set up a review with ward staff and GP of how to support and address diet and healthy weight management, and should review access to specialist dietician support. (Report to be forwarded to MWC within three months of this report).	Review conducted, all overweight patients referred to dietician by GP. OT and activity worker set up walking group. Exercise bikes bought. Cycling programme instigated. Gym is being upgraded after patients consulted and involved. Menus are being reviewed and drinks vending machine options reviewed, healthier low cal options.
Care planning processes should be reviewed to develop person-centred, outcome-focussed care plans for individuals.	We now have 50% compliance with this recommendation. This work will be completed by March 2014 and will be in place within all our day units. The managers are meeting monthly to rationalise record keeping and ensuring outcome-focus and personalisation are guiding principles to inform our work.
Updated risk assessment and management plans must be included in the care plan for each individual patient. The care goals should set out specific steps to managing each individual patient's recovery; the daily recording by staff should show evidence of how the patient has been in relation to their mental health, as well as physical health.	Risk Management plans to be updated. Practice development staff to support ward team to review existing care plans and institute strengths-based care planning. Rehabilitation care plans will be developed with community care managers for patients leaving in-patient care. Functional assessment and consequent occupational therapy plans to be instituted for each patient with priority to patients leaving hospital care as part of re-provision project.
All care plans should contain a life history which informs the care and support provided, particularly with regard to activities/meaningful engagement.	All residents have a new, separate file which contains a completed "My Life" document and a full assessment of past and present interests and hobbies. Meaningful activity programme is planned on a weekly basis and this is based on the information gathered from the assessments.

Adults with Incapacity (Scotland) Act 2000

Service type	Number of recommendations	%
Older people (private)	30	54
Older people (NHS)	16	29
Other services	10	18
All services	56	100

Fifty six of our recommendations related to the Adults with Incapacity (Scotland) Act 2000 (AWIA); the majority to services for older people both in care homes and hospitals.

We want to know that people are receiving treatment in line with the law, particularly in relation to Part 5 of this Act, as it provides important safeguards for people.

Section 47 of the Act authorises medical treatment for people who are unable to give or refuse consent. Under Section 47, a doctor or other authorised healthcare professional examines the person and issues a certificate of incapacity. The certificate is required by law and provides evidence that treatment complies with the principles of the Act.

Around half of all recommendations in this category related to the lack of Section 47 certificates and treatment plans where we felt they should have been in place, or where they were in place but not being completed properly.

The majority of the other recommendations related to lack of information available to staff about the specific powers that welfare guardians and powers of attorney have. It is important that staff know and understand about what it means to be a welfare guardian or attorney to ensure that the rights of the individual are protected.

The Commission has produced guidance for staff working with the *Adults with Incapacity Act in care homes .*

Some examples of our recommendations and outcomes

We recommended	The service responded
We recommend that staff clarify the status of any person who is a legal proxy under the AWIA, and ask for copies of any orders to be provided.	Action planned – patients and relatives to be asked, on admission, if there is a legal order in place, and staff to request copies of relevant paperwork and file in case close.
Information relating to welfare guardians and other proxies in care plans should be consistently documented with relevant contact information visible.	Information regarding welfare guardians and proxies is now consistently documented within the care plans of individuals. Where appropriate, we have requested from POAs, guardians, etc, a copy of the legal documents with which they exercise their role.
The manager should ensure existing Section 47 certificates and treatment plans where necessary are in place and accessible in case notes for all those who lack capacity to consent to treatment.	All required AWI forms are in situ and in conjunction, I have identified related treatment plans. There are approximately eight treatment plans still required, however they will be completed asap via GP reviews over the next two weeks.

Physical environment:

Service type	Number of recommendations	%
Older people (NHS)	13	28
Older people (private)	8	17
NHS adult acute wards	10	21
Other services	16	34
All services	47	100

Forty seven of the recommendations related to aspects of the physical environment of places where individuals we visited were living.

A common theme in services for older people was that we thought the environment was not dementia-friendly or enabling. This echoes our findings in 2012. The majority of these recommendations concerned services for older people; 13 in the NHS and 8 in care homes.

We highlighted the physical environment in *Dignity and Respect* – our recent national themed visit report to NHS continuing care wards for people with dementia.

Ten recommendations related to NHS adult acute wards. They were predominantly about a general lack of maintenance and refurbishment of in- patient wards.

Often we find that staff welcome our recommendations when these relate to estates departments in hospitals, as they find this helpful in making sure the work is carried out. We do not think it is acceptable that often it requires our intervention before works are carried out where it is clearly evident that such works are required and have already been requested by the care team. We raised this concern in our previous report but continue to hear from people about the difficulties they are experiencing.

We have escalated our concerns about the physical environment in some wards to the NHS Boards concerned and will continue to do so until these are resolved.

Some examples of our recommendations and outcomes

We recommended	The service responded
Managers need to set a timescale for the redecoration of the bedroom that has been damaged. The curtains should be moved to the inside of each of the windows to give patients some control over their own privacy.	Bedroom walls have been painted since visit. Works department has informed carpet will be replaced before December 2013. Observation policy being reviewed and will be considered as part of process. Information leaflet will be developed which will inform all patients of levels of observation.
Managers require an ongoing programme of maintenance and regular environmental assessments of the acute wards to maintain acceptable standards prior to their eventual re-provisioning. This in a particularly serious issue and we will bring our concerns to the attention of the Chief Executive of NHS Board.	All acute psychiatry wards have been audited through NHS Board Patient Quality Indicators and each of the wards has an action plan to address environmental issues and monies to undertake plan of work/refurbishment has been applied for. An escalation policy for non completion of routine maintenance work has been developed for clinical areas to ensure timeous completion of maintenance requests. All areas have an updated action plan for refurbishment/purchase of new equipment.
NHS should undertake an audit of the environment to identify features that are, or are not, dementia-friendly. If it is not possible to make sufficient improvements, the Board may need to reconsider the location of in-patient assessment facilities for people with dementia.	Dementia-friendly environment audit already undertaken (see attached audit report). Items identified for improvement: • Hi Lo baths x 2 obtained. Awaiting date for installation. • Small sitting area created by moving ward office. • Seating areas introduced in ward alcoves • Shower heads to be replaced with suitable alternatives within Ward A. • Replacement of door handles and replacement of shelving units progressing through procurement process.

Consideration needs to be given without delay to providing a quiet room that is actually quiet, where residents can go to relax and where the Snoezelen equipment can be accessed without interruption when an individual needs it.	Ironing room to be located to the laundry area. New quiet room to be located in this area. This has been completed.
The use of memory boxes is only of benefit to patients if they contain material relevant to individual patients. This should be acted on by staff with the support of relatives following discussion of life story work.	Nursing staff discuss and encourage the use of memory boxes with carers. However, following the recommendation of this report we have now introduced a 'memory box' information sheet into the carer packs and placed posters at the ward entrances.
An audit of the environment should be undertaken with a view to incorporating dementia-friendly design principles wherever possible.	A review of the unit's decoration and design, to meet the needs of the residents, has taken place. Appropriate signage, and pictures on doors, now in place to make the unit more dementia- friendly.

Service type	Number of recommendations	%
Older people (NHS)	9	22
Older people (private)	11	27
NHS adult acute wards	5	12
Other services	16	39
All services	41	100

Forty one of the recommendations concerned the provision of therapeutic activity.

Of those recommendations, the majority related to services for older people, both in NHS wards and private care homes.

In adult acute wards these tended to be about making sure that individuals felt involved in planning the activities on offer.

We highlighted the provision of activities in adult acute wards in our national themed visit report, *'Adult Acute Wards Visits 2012'* .

Some examples of our recommendations and outcomes

We recommended	The service responded
The ward should develop individual activity plans based on life story work.	Individual activity plans now incorporated. More work required in developing these based on life story work. Joint approach by nursing and OT staff.
Within ward X, each patient should have an activity plan tailored to their needs, incorporating a record of participation and outcome.	Following your report and my subsequent discussion with the charge nurse, the ward has reviewed the individual activity plans that they had been using for their patient group. They have adapted the activity form used by another ward to meet the needs of their own patient group. Please find a copy of this form attached. This has been implemented and is being worked through for all patients.
Unit manager and charge nurses should ensure patients are provided with a paper copy of their weekly planner and activity plan.	This has now been actioned. Each patient in collaboration with their named nurse agrees the activity plan that links to their overall recovery plan. Nursing staff now place a copy of the plan in each individual's bedroom for ease of access.

Twenty eight of our recommendations concerned the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA).

The Commission has a duty to monitor operation of the Act and one of the ways we do this is by visiting people subject to various provisions of the Act. On our focussed visits we meet with everyone who wants to meet with us, our role is in relation to all people with a mental illness or learning disability, those subject to the Act, and those not.

We do, though, check to make sure that no-one we visit is subject to de facto detention, and that those who are subject to the Act have all the necessary safeguards in place including completion of required documentation.

Of our recommendations, around a quarter related to ensuring that consent to treatment documentation (T2 and T3 certificates) was properly completed and easily available to those administering treatment. The other most likely areas were incomplete documentation relating to safety and security provisions, suspension of detention, and general recommendations about the management of MHA documentation.

The Commission provides good practice guidance on many of these subjects and can be accessed via our website.

Some examples of our recommendations and outcomes

We recommended	The service responded
Managers to review the T2 and T3 consent to treatment forms to make sure medication prescribed is properly authorised.	I have confirmed with Dr. X that all T2 and T3 forms have now been checked and respective medications are properly prescribed. This checking process will be repeated in September 2013.
As a matter of urgency, the unit manager should ensure care plans have a recording sheet for time off the ward where appropriate, and that all staff are aware of the importance of accurate recording of same.	This action is now complete. Each patient's time off the site on suspension of detention is recorded in the unit diary. Each week this is collated on a recording sheet for each patient, to make sure there is a running total of suspension of detention taken. This is presented at the patient's multi-disciplinary review for consideration by the Responsible Medical Officer (RMO). In addition to this local action, the action taken will be presented at the Mental Health and Learning Disability Clinical Governance Group for dissemination across Mental Health Services.
There should be a full review of management of specified persons procedures in the unit. It should be ensured that all required duties and notifications have been completed for all individuals who are subject to restrictions covered under specified persons procedures.	A review has been conducted by the Clinical Director. All RMOs involved have been requested to ensure that the MWC guidance for implementing specified persons regulations is applied appropriately. Dr X has also considered administrative issues and has requested that all associated RES forms are kept within the legal file for ease of access. Systems for ensuring that all paperwork is up to date have now been reviewed and are in place.

Medication and access to medical care and treatment

Service type	Number of recommendations	%
Older people (private)	7	29
Adult acute (NHS)	6	25
Other services	11	46
All services	24	100

Twenty four of the recommendations we made concerned medication and access to medical care and treatment.

Of these, around a quarter were made in care homes for older people and a quarter in adult acute NHS wards.

In care homes for older people, the recommendations tended to be about ensuring regular medical reviews of patients' medications, particularly psychoactive medications. We raised serious concerns about prescribing of psychoactive medication in people with dementia following our recent national themed visit to NHS continuing care wards and more information about this can be found in our report '*Dignity and Respect*'.

In adult acute wards, these tended to be about poor prescribing e.g. lack of information in relation to "as required" prescriptions and limited input from a pharmacist.

We recommended	The service responded
Arrangements should be put in place to ensure pharmacy input to ward rounds.	I can confirm we have discussed the matter with the lead pharmacist and have subsequently been working closely with the senior pharmacist at hospital X who currently provides input to Ward A. In conjunction with the pharmacy service, we have prepared a job description and post brief (and associated budget) to provide three sessions per week of pharmacy input (in addition to current technician support). The recruitment process will be taken forward by our pharmacy colleagues and we are hopeful the position will be filled shortly.
Psychotropic medication should be reviewed on a regular basis, taking account of changes in the individual's physical condition and behaviour. Where individuals are receiving high dose antipsychotic medication there should be regular high dose monitoring.	Plan for review of psychotropic drugs to be implemented. All drugs reviewed by CPN, GP and psychiatrist and review documented in care plan.

Restrictions:

Service type	Number of recommendations	%
Older people (NHS)	4	44
Other services	5	56
All services	9	100

Nine of the recommendations we made related to restrictions on the individuals that we met.

Of these, four related to NHS wards for older people and three were about a lack of a clear locked door policy.

We recommended	The service responded
The arrangements for managing access to the functional assessment unit should be reviewed. The Commission would expect that any restrictions placed on the personal freedom of individuals be the least restriction possible.	Locked door policy reviewed with staff and patients of Ward A. Safe systems introduced to support the implementation of above policy.
The manager should carry out an urgent review of policy in relation to searches, and restrictions or monitoring of correspondence and phone calls, and must ensure all staff are fully aware of policy and make any individual subject to such measures aware of their rights to seek review by RMO and rights of appeal. The reviewed policy should be forwarded to MWC within two months of this report.	Policy sent to MWC. RMO confirmed that in future the unit will follow MWC guidelines.
We recommend that when specific restrictions are discussed with individual people who are informal patients, and agreed and accepted by them, this is clearly documented in their notes.	In the cases where specific restrictions are discussed with individuals who are informal, it is recognised that these are recommendations/suggested interventions and usually relate to their individual risk assessments. Formal detention measures will be implemented if required should patient meet the criteria for detention.

The remaining recommendations we made (37) concerned training for staff, involvement of carers, risk assessment, patient safety issues and other miscellaneous recommendations e.g.

We recommended	The service responded
The issue of anti-ligature shower rails, curtains and privacy when using the shower need addressed as soon as possible. A more effective alert that the shower is occupied needs to be put in place.	We regret the significant delay in resolving this issue which was a precautionary measure following an adverse incident. Our shower rails required a 'load bearing' retest by Estates department. The shower curtain rails have now been re-installed and locks have been put on all the toilet doors to maintain privacy.
Managers should review the training and support needs of the ward team in relation to caring for patients with eating disorders.	We recently introduced a mealtime co-ordinator within each of our wards to ensure that mealtimes are protected for patients. Our mental health advance nurse practitioners who are based in the hospital have the required competencies and are available to train staff as and when required. The SCN for the ward also arranged for the specialist nurse in nutrition to deliver training to staff on the use of a naso-gastric tube.
Managers to ensure the Commission are informed of relevant incidents promptly.	I can confirm that a full and fundamental review of incident and accident procedures has been completed. These are now subject to monthly audits.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