

**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**

Lammerlaw Ward, Herdmanflat Hospital, Haddington EH41  
3BU

**Date of visit:** 24 January 2017

## **Where we visited**

Lammerlaw Ward is a 16-bedded, mixed-sex, inpatient, complex care ward for older people with a diagnosis of a dementia. The ward is the only inpatient service remaining on the Herdmanflat site. We last visited this ward on 27 May 2015 and made a number of recommendations related to care planning, activity provision and the legal authorisation for individuals' treatment as Part 16 of the Mental Health Act (MHA).

We chose to follow up on these recommendations and also to hear of any other issues raised on the day either by patients, relatives or staff.

## **Who we met with**

We met with and reviewed the care and treatment of seven patients and the relatives of two patients. We also met with three staff nurses and the activities coordinator. This was an unannounced visit and the charge nurse and deputy charge nurse were not available on the day of our visit due to training commitments off site.

## **Commission visitors**

Moira Healy, Social Work Officer

Dr Mike Warwick, Medical Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

The individuals who we met with, and the patients we were able to observe, appeared to be well looked after. One patient wished to raise an issue with us regarding one aspect of their care. The Commission visitor who spoke to them informed the charge nurse the next day, who planned to meet with the patient and their relative to discuss their concerns. He said he would look into these and take action if indicated.

We took the opportunity to look at care plans, daily progress notes, weekly ward round documentation and multidisciplinary team (MDT) reviews.

When reviewing care plans we found them to be mainly generic with only occasional personalised information contained within. Interventions such as 'use distraction techniques' which related to an individual whose behaviour was, at times, agitated or distressed, rarely described what distraction techniques would be useful for that person. In addition, care plan reviews were generally not meaningfully evaluated, e.g. a comment such as 'continue with current care plan' being the only statement that indicated any review. This is not an indication of how the plan was working and

did not detail any amendments which may be needed to improve the interventions described.

### **Recommendation 1:**

Ward manager and clinical nurse manager should conduct an audit of all care plans and reviews to ensure they are person-centred, individualised and, in particular, describe specific interventions in relation to the management of that individual's behaviour.

### **MDT reviews**

The MDT recording sheets were used on a weekly basis. They were dated, included all in attendance and each indicated clearly the plans that had been made for the following week. There also was an evaluation of goals achieved or which were still in progress.

### **Use of mental health and incapacity legislation**

We found paperwork in relation to those patients detained under the MHA up to date and easy to locate within the files. However, there was a lack of clarity amongst the trained staff in relation to who was and was not a detained patient. Information in relation to this, which was recorded on a whiteboard in the nurses' office for ease of reference, had not been updated in some instances and this perhaps accounted for the confusion amongst the staff.

### **Documentation in relation to Adults with Incapacity (AWI) Act welfare proxies.**

The trained staff we spoke to seemed unclear for some patients about whether they had a welfare guardianship or power of attorney (POA) in place. This information was not recorded on the front sheet of the person's file and documentary evidence was at times not easy to find. This legal documentation is very important. It is advisable to record who holds proxy decision making powers on a front sheet within the patients file. We recommend using the checklist from the Mental Welfare Commission guidance 'Working with adults with incapacity' to record who the legal proxy decision maker is and any delegation of these powers by the proxy. A copy of the powers should be held in the same place in each patient's file. This helps to ensure that all staff are aware when a patient has a welfare proxy, who this is, and when they should be consulted.

### **Recommendation 2:**

The ward manager should ensure that the legal status of the each patient is clearly recorded. For those patients who have a proxy decision maker, this person(s) should be clearly recorded and there should be documentary evidence to support this within the patients file.

## **Covert medication**

A number of patients were currently receiving, or had previously received, covert medication. Mental Welfare Commission covert medication pathways were in place, which is good practice. However, these were not all written on the current proforma, which includes a section for detailing the method of administration for each individual medication. This information was generally not well recorded. Covert medication planning should result in the doctor documenting a 'recipe' on the pathway for giving each medication safely in covert form. Nurses should compile a care plan to support the covert administration of medication, including the way that each medication is administered.

There were some covert medication pathways in the medication folder without documentation with them that these had been reviewed. We recommend that the Mental Welfare Commission covert medication pathway review form should be used and filed with the pathway. Any outdated pathways for patients no longer receiving covert medication should be removed.

The Commission's good practice guidance on covert medication and pathway proformas are available on our website:

<http://www.mwscot.org.uk/publications/good-practice-guides/>

### **Recommendation 3:**

Medical staff should review covert medication care pathways and ensure that these are fully completed on current proformas. Nursing staff should ensure that detailed care plans are in place for administration of each medication given covertly.

## **Consent to treatment**

Where an individual lacks capacity to make a decision in relation to medical treatment(s), a certificate under s47 of the AWI Act must be completed to authorise that treatment, unless it is treatment given under the authority of the Mental Health Act (MHA).

The s47 certificates and treatment plans we saw properly covered individual treatments, except in one case. That s47 certificate, and a treatment plan for another patient, both contained general statements that did not cover any particular treatment. These were actually issued by medical staff in another ward prior to the patient being transferred to Lammerlaw. We have drawn this to their current consultant's attention.

## **Do not attempt cardiopulmonary resuscitation (DNACPR) forms**

We saw DNACPR forms in place for some patients whose notes we reviewed. In two cases, the patient had a welfare POA, but the doctor had completed the form without documenting on it that there had been discussion with the attorney. In one of these cases they had consulted another relative thinking they were the attorney, which emphasises the importance of easy access to clear information about the POA as above. Both these DNACPR forms were issued by medical staff in another ward prior to the patient being transferred to Lammerlaw.

The Scottish Government's DNACPR policy (2016) states *"It is both good practice and may be legally required to consider and communicate CPR decision-making within the context of exploring goals of care and appropriate levels of escalation of treatment with the patient, any welfare attorney/welfare guardian or others close to the patient."*

The above highlights that it is important for medical staff in Lammerlaw to check s47 paperwork and DNACPR forms where patients are transferred from other wards, and ensure that these are properly completed. Any problems identified should be drawn to the attention of the medical staff who completed the forms for their future learning.

### **Recommendation 4:**

There should be an audit of all DNACPR forms. This should include ensuring that, if the patient has a welfare POA or welfare guardian, there has been discussion with them as per the Scottish Government's DNACPR guidance:

<http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/peolc/DNACPR>

## **Activity and occupation**

The ward has a full time activity coordinator. There is also input from an occupational therapist (OT) technician for three sessions per week. We met with the activities coordinator and heard about her work on the ward. She advised us that both the activities coordinator and the OT technician work with individuals in a group and have a wide variety of activities available for individuals to participate in on the ward. They also see the importance of taking patients out and going for a walk in the hospital grounds and where possible on trips outwith the hospital grounds.

All patients have a copy of their individual activity planner held in a separate file and it is completed every day if they participate in activities. Efforts are made to encourage patients to participate in activities but, when they refuse, this is sometimes not recorded. Unfortunately, due to wearing the same uniform as the health care assistants, the activity coordinator is not distinguishable from them and we were told this can create confusion amongst some patients (when she is not

responding to their immediate nursing needs in the way a health care assistant would). There is also a disadvantage in that the activities coordinator can be expected to join the staffing rota as a health care assistant when the ward is short staffed. This needs to be addressed.

## **The physical environment**

Lammerlaw is an old ward and will be moving to a new ward on the Roodlands site in several years' time. The living/dining area is spacious, and is bright and clean.

We had concerns about the whiteboard within the nurses' office. It contains highly confidential information and can be viewed from the window in the lounge area. A roller blind, which can be used to discreetly cover this information when not needed, was not used on the day of the visit. The siting of this board, or its replacement, needs immediate attention and this was raised with the ward manager within two days of the visit.

The bedroom corridor, which also accommodates a smaller, quieter lounge, is quite separate from the living area. To gain access to this corridor there is a keypad system in place. This acts as a barrier for those patients who may wish to use this lounge, their bedroom, or return from that area to the main part of the ward.

Bed spaces were often not individualised and there seemed to be little indication of whose bedroom or dormitory accommodated which patient.

There are limited facilities for people to have privacy with visitors or meetings. We experienced this when we met with a patient and their relative. The quiet sitting room was being used by another patient, and the one meeting room is at the far end of the bedroom corridor. This was quite a distance for the patient, who is physically frail, to walk, and the room is often used by staff when on their breaks.

### **Recommendation 5:**

The locked door leading from the main part of the ward to the bedroom area should be reviewed so the patients have easier access.

### **Recommendation 6:**

The ward manager should look at personalisation of bed spaces and there should be an indication on the doors as to who has their bed in the room.

## **Summary of recommendations**

1. Ward manager and clinical nurse manager should conduct an audit of all care plans and reviews to ensure they are person-centred, individualised and

describe specific interventions in relation to the management of that individual's behaviour.

2. The ward manager should ensure that the legal status of the each patient is clearly recorded. For those patients who have a proxy decision maker, this person(s) should be clearly recorded and there should be documentary evidence to support this within the patients file.
3. Medical staff should review covert medication care pathways and ensure that these are fully completed on current proformas. Nursing staff should ensure that detailed care plans are in place for administration of each medication given covertly.
4. There should be an audit of all DNACPR forms. This should include ensuring that, if the patient has a welfare POA or welfare guardian, there has been discussion with them as per the Scottish Government's DNACPR guidance.
5. The locked door leading from the part of the ward to the bedroom area should be reviewed so the patients have easier access.
6. The ward manager should look at personalisation of bed spaces and there should be an indication on doors as to who has their bed in the room.

## **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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