mentalwelfare commission for scotland

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VISIT AND MONITORING REPORT

Focussed visits overview 2012-13

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 for example 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.

We achieve this by carrying out focussed visits to particular services or facilities. We undertake focussed visits for various reasons. We visit some facilities, for example, secure units, more often since they place more restrictions on an individuals' freedom.

In some cases, we undertake focussed visits in response to concerns we have received or have expressed on previous visits. We also visit if it has been sometime 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 2012 and December 2012 we carried out 133 focused visits to 126 services (in some cases we visit the same service more than once). We count a visit to several wards in one hospital on the same day as one visit.

We made 491 recommendations relating to our visits.

Compared with previous years there has been an increase in the number of focussed visits and recommendations.

Once we have made our recommendations we give the service three months to write to us with their response. If we feel the recommendation is particularly serious we reduce the response time so that it is treated as urgent.

Once we receive the response from the service it is allocated to the Commission officer who was the lead on the visit to the service. The Commission officer will review the response and decide if the response is adequate or if we need further information. When we return to services we will confirm for ourselves that the recommendations were carried out.

This visit year we committed to undertake follow up action on 90% of our recommendations. We have undertaken this in 97% of our recommendations.

We are pleased to report that 93% of the recommendations we made have been fully implemented or resulted in significant service changes.

We believe this shows that our visits and recommendations have helped to influence service improvements.

We send copies of our visit reports containing our recommendations to the Care Inspectorate for visits to care homes and to Healthcare Improvement Scotland for NHS services and private hospitals. We aim to make sure that these organisations are aware of concerns that we may have raised and they can then choose whether to look further into these.

Our report identifies the main issues raised following our focussed visits and then looks at where we were most likely to make recommendations. We also give some specific examples of where improvements have been made that 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	13	*10*	33	*7*
Private hospital adult mental health	1	*1*	3	*1*
NHS wards for older people mental health	37	*29*	164	*33*
Care homes for older people	23	*18*	99	*20*
NHS forensic psychiatry wards	6	*5*	21	*4*
Private hospital forensic psychiatry wards	2	*2*	8	*2*
NHS General Hospital	1	*1*	6	*1*
NHS wards for people with learning disability	13	*10*	52	*11*
Care homes for people with learning disability	6	*5*	22	*4*
Prisons	9	*7*	20	*4*
NHS ward adult rehabilitation/continuing care	7	*6*	41	*8*
Private care provider/care home for adult rehabilitation/continuing care	4	*3*	10	*2*
NHS ward for young people/mental health	3	*2*	11	*2*
Private hospital for young people/mental health	1	*1*	1	*0*
	126	***100%***	**491**	***100%***

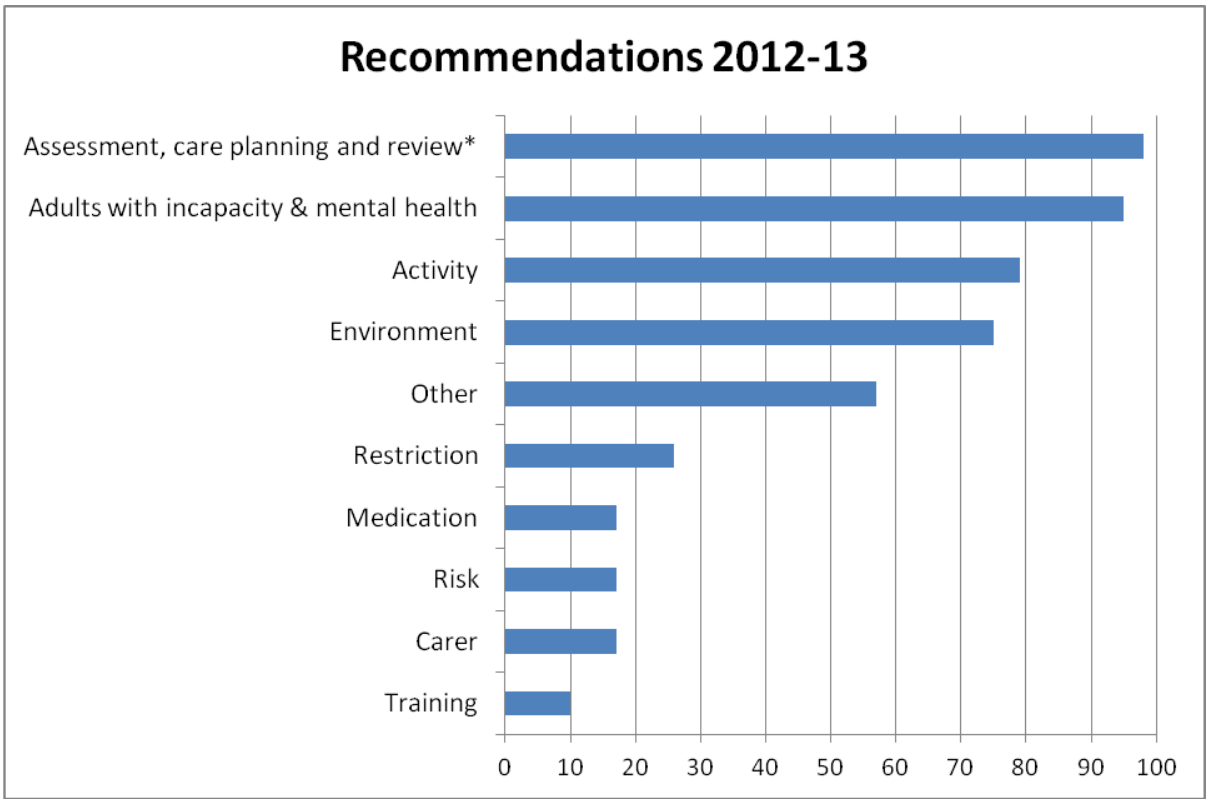
Services for older people are the largest grouping and represent the bulk of visits; they also generated the majority of recommendations over the visit period 2012-13.

The service generating the highest number of recommendations per service was NHS adult rehabilitation/continuing care wards (6), followed by older people (NHS 4.4, Private 4.3). Other services generated 1-3 recommendations per visit.

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
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Therapeutic activity
- The physical environment
- Restrictions
- Carers
- Medication
- Risk assessment
- Staff training



**Includes person centred care*

Assessment, care planning, review and person centred care

Service type	Number of recommendations
Older people (NHS)	32
Older people (private)	21
Learning disability (NHS)	12
Adult rehabilitation (NHS)	8
Other services	25
All services	**98**

Ninety-eight 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. The majority of these recommendations related to both NHS and private services for older people.

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

We often found it difficult to find key information within the documentation used by staff. At times we found documentation and recording confusing to follow. We also found it could be hard to gain a clear picture of the care plan and review process for the individual.

We think that if our visitors are unclear about the care plan after reviewing the documentation then it is highly likely that the individual we are visiting and staff will be too.

Some examples of our recommendations and outcomes

We recommended	The service responded
Summary versions of care plans that are accessible to the individual should be routinely available.	*The learning disability care group has commissioned a sub group to develop a format for accessible care plans.*
There should be a review of the care planning process to ensure that in addition to the necessary documentation required by staff, care plans reflect the participation of the individual. Staff should be encouraged to use varying means of communication to enable individuals to access key parts of their care plans.	*Have now begun to implement CPAs (Care Programme Approach) for all patients and a schedule of reviews have been planned with two patients successfully supported to participate for a period during the review. Our head occupational therapist is leading on the development of communication supports and easy read information for our patients service wide.*
Procedures for more person centred, collaborative, recovery focussed care planning should be further developed.	*The care plans have been revised to reflect a more recovery focussed approach (a copy was provided).We undertook to complete the Scottish Recovery Indicator tool audit and overall the results were positive. We have taken steps to address the areas which required improvement and it is our intention to repeat the audit in approximately 6 months.*
It is essential that care plans reflect the reality of the patient's care needs and are reviewed to reflect changes as they occur. Managers should review care plans and ensure systems and training are put in place where necessary to address this.	*The unit will have comprehensive person centred care plans within 6 weeks and life story work completed within 12 weeks for all newly admitted patients. (Example of a 6 week plan copied and sent to the Commission).*
Medical and nursing staff should arrange a meeting with the advocacy service to explore the concerns expressed in relation to care planning and patient's involvement in their care.	*A plan is in place for the senior charge nurse to consult with young people and parents/carers over changes to the care planning meetings and admission process to ensure that the process is person centred and the views of young people and their parents/carers are the starting point for planning. Following consultation, these changes will be implemented and reviewed via feedback from advocacy and directly with patients/carers and service users.*

Adults with Incapacity (Scotland) Act 2000

Service type	Number of recommendations
Older people (NHS)	31
Older people (private)	27
Learning disability (NHS)	6
Other services	9
All services	**73**

Seventy-three of our recommendations related to the Adults with Incapacity (Scotland) Act 2000. The majority related to services for older people and for people with a learning disability.

We want to know that people are receiving treatment in line with the law, particularly in relation to Part 5 of this Act that 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 to treat those who lack capacity and provides evidence that treatment complies with the principles of the Act.

In this category, just over half of our recommendations related to Part 5 of the Act. We did not think that Section 47 certificates of incapacity and treatment plans were being completed properly.

Please also see our report on our visits to care homes and hospitals to monitor use of Section 47 certificates, May 2013 - **AWI part 5 monitoring**.

Around 35% of recommendations in this category related to either Powers of Attorney or Welfare Guardians under the Act.

We think it is important that staff know when someone has a proxy decision maker and what their powers are but we found that often staff had very limited information about this.

We also found that staff were often confused about what it means to be a Welfare Guardian or Attorney and the decisions they can and cannot make.

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

Some examples of our recommendations and outcomes.

We recommended	The service responded
The Adults with Incapacity Act requires consent to treatment certificates for all interventions, not just for operations, where the adult is unable to give consent. We recommend a review of present procedures so that capacity and consent is assessed and recorded for all healthcare procedures. Where the adult lacks capacity, appropriate documentation should be in place for the totality of the persons care.	*Practice has now been changed to include all treatment whilst in hospital rather than just the surgical procedures.*
It is important to identify welfare proxies who may have powers to consent to treatment and should be consulted over decisions. This information should be gained on admission so that appropriate consultation can take place.	*Nursing documentation now includes a question on welfare proxies which has resulted in early identification.*
Manager to speak to GPs regarding updating consent to treatment certificates.	*All Section 47 certificates and treatment plans are now up to date and completed fully.*
We recommend ward staff should be considering guardianship at an early stage in the assessment process so that an individual's move to a more suitable environment is not unduly delayed.	*Status is now being discussed at MDT meeting with a view to implementing process of application as soon as future care needs have been decided. Named nurse and associate worker have responsibility for liaising with social work department at least weekly to check on any progress. All communications regarding this are being recorded in the care plan*.

Mental Health (Care & Treatment) (Scotland) Act 2003

Service type	Number of recommendations	%
Adult acute (NHS)	5	*23*
Adult rehabilitation (NHS)	4	*18*
Other services	13	*59*
All services	**22**	***100***

Twenty-two recommendations concerned the Mental Health (Care & Treatment) (Scotland) Act 2003.

These recommendations included

- ensuring that duties under Section 278 (parental relations) were understood
- specified person provisions and safeguards were understood and implemented
- ensuring patients were informed of their legal status and rights under the Act,
- ensuring that consent to treatment forms (T2 and T3 forms) were in place where required,
- recommending regular audit of T2 and T3 forms and ensuring that a copy of the form is kept where staff who need to see it can easily access it.

We produced a report on our monitoring of Section 278 this year, **When parents are detained**.

Some examples of our recommendations and outcomes

We recommended	The service responded
Managers should review procedures to ensure that patients are timeously informed of their legal status and associated rights.	*An information leaflet for patients explaining the different levels of observation, from general observation to constant observation and special nursing has been developed. This also now has a section on patients' legal status and associated rights.*
Priority should be given to ensuring that duties under section 278 are understood and attempts should be made to mitigate the effect of compulsory measures on parental relations.	*Senior charge nurse met staff members to ensure all are aware of s278 & their responsibilities regarding parent /child relationship .S278 training to be introduced.*
Systems should be in place to ensure that the RMO reviews reasoned opinions and renews specified persons authority on an individualised basis when indicated. It should be ensured that individuals benefit from the safeguards of this legislation and that they are aware of their rights to ask for their specified person's status to be reviewed.	*Specified persons renewal process has been reviewed and we will routinely review the status at each CPA.*
The arrangements for accessing advocacy services should be modified so that residents who are currently unable to access advocacy can have this need met. (Access to independent advocacy is a right under the 2003 Act)	*A questionnaire is to be devised for residents in relation to accessing advocacy, their wish to do so and any changes they feel would be of benefit. Questionnaires will be reviewed and any actions/amendments suggested will be raised and discussed with advocacy services.*

Therapeutic Activity

Service type	Number of recommendations
Older people (NHS)	28
Older people (private)	19
Forensic (NHS)	8
Adult rehabilitation (NHS)	6
Other services	18
All services	**79**

Seventy-nine of the recommendations concerned the provision of therapeutic activity.

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

We found that too often, activities were provided in a one-size-fits-all way. The activities provided did not take into consideration the personal preferences or abilities of the individuals who were taking part in them.

We feel that activity provision should be based on an individual's assessed needs, taking into consideration their previous and current preferences.

Often, but not always, staff recorded activities that people were involved in. Whilst this is positive, we think this should also include an evaluation about whether or not the activity was a success.

Providing therapeutic activities to people with different needs and preferences is a very skilled task and we are often impressed by the enthusiasm and skills of people who do this.

Sometimes we found that activities were viewed by staff as being someone else's responsibility or only that of the occupational therapy department. It is important to clearly identify who is responsible for activities within ward and care home settings since individuals can live there for a long period of time.

Our recent report on our **visits to adult acute** admission wards across Scotland highlighted the importance of providing therapeutic activities during the evenings and at weekends. Individuals said they found therapeutic activities to be of benefit but noted that they were often only available on weekdays between 9am and 5pm.

Some examples of our recommendations and outcomes

We recommended	The service responded
Recording of activities carried out should be standardised so that these are available in the patient record'.	*All patients now have an individual activity sheet within their personal care plan. Documentation used has been taken from the activities tool kit and staff have been trained by the occupational therapist that developed the kit*.
The ward manager should undertake a further consultation with young people about the extent and range of activities available after school and report back to the Commission by end February 2013.	*A review was undertaken, The Young people were consulted and meetings arranged as well as 2 suggestion boxes put in place. A quiz night and movie night have been put in place as a result. A full activity timetable for groups is available and is augmented by an individual timetable*
The new activity assessment documentation should be completed for all the residents as soon as possible.	*The activity co-ordinator is undertaking individual assessment of all residents and an individual plan will be compiled from the initial assessment. Each resident will have their own activity file as well as their activity planner kept in their room.*

Physical environment

Service type	Number of recommendations
Older people (NHS)	32
Older people (private)	14
Learning disability (NHS)	9
Adult rehabilitation (NHS)	9
Other services	11
All services	**75**

Seventy-five of the recommendations related to aspects of the physical environment where individuals were living.

A common theme in services for older people was that we thought the environment was not dementia friendly or enabling. There is good evidence that making the physical environment dementia friendly improves orientation for people with dementia and reduces levels of stress and distress. We often commented that signage was inadequate. We recommended that services carry out a dementia design environmental audit.

We made some recommendations about inadequate bath and showering facilities but mostly these concerned facilities in older buildings. Many of the recommendations highlighted that privacy and dignity were being compromised because of, for example, the absence of adequate blinds and curtains or the presence of unpleasant odours.

We made recommendations regarding the general maintenance of some NHS wards and care homes for older people. Often these recommendations would not require costly changes but pointed to improvements that could be made and the need for general maintenance and renewal of soft furnishings.

In some cases, we commented on garden space that was unsuitable and/or difficult to access easily. For many people in hospitals and care homes, their only access to outside space and fresh air is the garden area and we found that these were often neglected and under used.

In NHS learning disability and private care homes our recommendations about the environment were predominantly about inadequate maintenance and we recommended improvements were made.

In wards and care homes for people with severe and enduring mental illness where there was a focus on rehabilitation, recommendations mainly related to a lack of

personalisation of the environment and the need for general refurbishment of buildings.

We made only three recommendations in adult acute NHS wards about the physical environment. These related to recommending general refurbishment within a ward, upgrading shower facilities and looking at ways to reduce noise levels in communal areas. We received satisfactory responses to these recommendations.

We often find that staff welcome our recommendations relating to work by the 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 it often requires our intervention before work it carried out where it is clearly evident that such work was required and had already been requested by the care team.

Some examples of our recommendations and outcomes

We recommended	The service responded
In X the damp in the shower-room and shower water running out from under the door should be addressed. The need for frosting on the sitting-room patio doors in X should be reviewed and removed if no longer necessary. Alternative measures should be considered.	*Maintenance works are now completed as requested.*
Managers should consider what alternatives can be put in place to ensure sufficient ventilation is available for patients who are in bedrooms with no access to fresh air.	*Following the recent visit, we are exploring costings for supply and fitting of windows which allow ventilation which does not compromise safety and security of the ward.* We accepted this response and will check on progress at our next scheduled visit to this service.
The service manager should undertake a rigorous review of the internal environment with staff and young people and forward an action plan on this to the MWC by February 2013.	*A review and consultation took place. A welcome sign will be erected; art work and plants for the main corridor and wards will also be purchased. Families have been advised that the dining-room can be used a communal visiting area. Security fencing is being erected around the garden area to allow its use.*

Restrictions

Service type	Number of recommendations
Older people (NHS)	8
Learning disability, adult acute , forensic (NHS) and older people (private) (3 each)	12
Other services	6
All services	**26**

Twenty-six of the recommendations we made related to restrictions placed on the individuals that we met.

The majority of these recommendations related to services for older people, both in NHS and private care homes.

Our recommendations often referred to the main door into a ward or care home being locked and a lack of a clear policy about this.

There may be occasions where it is necessary for the safety of an individual that a door is locked. This should only be done in response to a recognised risk that cannot practically be met in any other way. We think that a locked door policy should clearly state the reasons why it is felt justifiable to lock the door. It should also state the process and frequency for the review of this decision. Patients and residents should know how to exit the building should they choose to do so.

Some examples of our recommendations and outcomes

We recommended	The service responded
Managers should insure that a locked door policy is put in place that includes letting patients know how they can exit the ward should they choose to do so (NHS ward).	*The unit team have included in individual care plans, the opportunities for time off the ward and what support would be required. The clinical nurse manager has led on a piece of work in respect of the use of technology as regard to locking of doors, door exit processes etc. The consultant nurse for older people has completed a draft document in respect of locking doors that includes informing patients on how they can exit.*
When bedrails are used, there should be a clear risk assessment and documentation as to whether the use constitutes a restraint and a specific care plan for this.	*MWC Good Practice guidance, Rights, Risks & Limits to Freedom, redistributed to nursing staff. When a possible need for use of bedrails is highlighted, a full Assessment of Needs will be completed by the multi-disciplinary team. This will be recorded in patient case files. Full risk assessment and care plan with weekly review will be completed and agreed by the multi-disciplinary team.*
Managers and the relevant clinical team should review the restrictions on patients accessing their rooms and ensure that the need for any such restrictions are individually assessed and implemented (NHS medium secure).	*A multi-disciplinary group has been established to review patient access to bedrooms; a paper is being developed for review by operational managers.* (We regularly visit this service so will be able to check further on progress of this recommendation)

In learning disability wards and care homes there were similar issues. We made recommendations in relation to CCTV, review of restraint, locked door policies and enabling patients to have access to their private space during the day.

We recommended	The service responded
The manager should discuss with senior managers having cameras in bedrooms removed completely. They should also continue to ensure use of CCTV in public areas is reviewed regularly and discussions documented.	*The X Council agree that the cameras should and will be removed. The manager will insure that this is carried out. The manager will also continue to monitor and review the use of CCTV in public places and record the benefits of these in individual support plans. The use of cameras will also be discussed during the care programme approach meetings and discussion will be noted in the minutes of those meetings*.
The care home manager should pursue efforts to enable residents to have the choice to hold keys to their own bedrooms if they are assessed as safe and able to do so (care home).	*All residents have been risk assessed in relation to their ability to hold a key to their own bedroom. A care plan is to be devised for each resident who has been assessed as appropriate to hold their own door key documenting what steps are required to support the resident to keep this safe. Where appropriate and the resident has stated they would like to, each resident is to be given a key to their own room*.

Carers

Service type	Number of recommendations
Older people (NHS)	6
Adult rehabilitation, adult acute, learning disability, young people (all NHS)	8
Other services	3
All services	**17**

Seventeen of our recommendations related to engagement with informal carers and improving communication between staff and carers/relatives.

We also recommended that information from informal carers should be carefully documented and incorporated into the assessment process. In one adult mental health ward, we recommended that managers ensure information regarding confidentiality is shared with patients and their carers at the beginning of engagement.

The manager responded that they have updated their carers' information leaflet adding in information about communication and confidentiality and providing a link to the Commission's good practice guidance on **Carers and Confidentiality**.

We were most likely to make recommendations in wards and care homes for older people.

Some examples of our recommendations and outcomes.

We recommended	The service responded
Senior nurses should ensure all staff are appropriately recording contact with families clearly in care files.	*All nursing staff will be briefed via registered nurse meetings/ward meeting and via the Named Nurse structure of the need to record contact with family/carers in the case files. The ward is enrolled in Scottish Recovery Indicator 2 and is currently working through data collection process which will inform and support the need and importance of family and carer involvement.*
Managers should ensure information regarding confidentiality is shared with individuals and their carers at the beginning of engagement both verbally and in writing.	*Confidentiality and communication with carers is discussed with the individual during the assessment and engagement phase. The team have updated their carers/ information leaflet adding in information about communication and confidentiality and adding in the link to the MWC website Good Practice Guidance on Confidentiality. The carer's leaflet will be given out at the start of treatment, it is to be published and put on the website. Beyond these immediate changes, we are exploring a number of ideas around service improvement.*
Managers of the service should review the current system for sharing information with patients and relatives to identify where improvements can be made and we would wish to be advised of subsequent plans to implement measures to improve communication.	*Communication to be explicitly discussed with patients/relatives/carers at the point of admission. Agreement on who will contact who at what time etc and this will be documented in the patient care plan. We will develop an information sheet which can be given out on admission which explains the best way to give and receive information.*

Other categories

Risk

Seventeen of our recommendations related to assessment and management of risk.

Whilst this is part of care planning and review, these recommendations related directly to risk and we thought we would identify these separately.

We sometimes felt that risk management was viewed as a 'box ticking exercise' and that risk identified was not always appropriately addressed in the care plan.

We recommended	The service responded
The service should consider reviewing the risk assessment and risk management policy which will set a standard for the unit.	*Standard operating procedures have been reviewed and include a redesigned appendix defining where the risk assessments are located and who has responsibility for them and when they are to be completed/reviewed and by whom.*
We recommended risk assessment and risk management plans should be reviewed regularly and audited.	*The nursing team have relooked at the process of review of risk assessments, have been completed and now updated resident's personal plans.*
There should be a review of the expected content of risk management plans and treatment plans. It should be clearly stated in care plans what needs they are addressing. Nursing assessments and documentation should be audited to ensure that key information is recorded and documentation is signed and dated.	*All of the risk management plans have been reviewed and updated within the ward. The charge nurse has liaised with her clinical nurse specialist and has embarked upon a process* of self auditing in addition to the annual audit carried out by the service.
Procedures for conducting and documenting risk assessment, risk management and review, should be clear to staff and routinely undertaken.	*Procedures for documenting risk management are under review. Each discipline undertakes risk assessments and develops a risk management plan bespoke to their discipline. We are currently developing a template for risk management plans which will be adopted by all disciplines and will be held centrally in the main patient case file and a process will be developed to have these regularly reviewed at the multi-disciplinary team meeting and any updates will be documented.*

Training

We highlighted some areas where we felt staff training and education was lacking.

These tended to be in relation to mental health and incapacity legislation but also included some other issues.

We recommended	The service responded
We recommend that the NHS Board reviews the delivery of mental health first aid training within HMP and develops a strategy for undertaking of training of prison officers.	*Newly recruited staff to post will have full NHS and local induction into the service.*

Other recommendations included further training for psychiatric medical records officers and dementia specific training for staff in care homes where the majority of residents have dementia but few staff had access to specialist training.

Medication and physical healthcare

These recommendations included:

- asking managers to carry out regular audits of drug prescription and recording sheets
- having appropriate policies and procedures in place regarding the administration of medication
- ensuring pharmacy involvement in covert medication care planning
- ensuring that high dose monitoring of anti-psychotic medication is carried out appropriately.

We commented on some occasions that routine physical health screening should be carried out at least annually.

Next year we are going to look at our recommendations to see if any of these relate to patient safety issues in hospital and will let the Scottish Patient Safety Programme (mental health) know our findings.

Other recommendations

There were some recommendations that did not easily fit in any of the above categories and these included:

- reviewing smoking policies in hospitals and care homes
- implementing catering satisfaction surveys
- reviewing locum arrangements
- reviewing how consultant cover is provided in an acute inpatient unit
- reviewing the skill and staffing levels in wards and care homes.
- addressing inadequate provision of interview facilities in a prison
- reviewing policies and procedures regarding use of patients' and residents' funds

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