mentalwelfare
commission for scotland

Recommendations and outcomes from our local visits 2016

August 2017

Contents

The Mental Welfare Commission

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

About our local visits

One way of achieving our mission is by carrying out local visits to people using particular services or facilities. We undertake local 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 local 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 information we have.

Between 1 January 2016 and 31 December 2016 we carried out 94 local visits and made 329 recommendations relating to these visits.

From December 2015, we started publishing local visit reports from NHS services on our website and from1 June 2016 this was extended to include care homes, prisons and independent hospitals.

Our visits are not inspections and we do not grade services. An inspection looks very closely at particular national and local performance standards. Whilst we want to know if people are receiving the standards of care they are entitled to, we do not measure against particular standards .The Care Inspectorate carry out inspections to registered care services and Healthcare Improvement Scotland to some hospitals.

Our visitors do, however, take into account any applicable national standards and good practice guidance. Our findings and the recommendations we make will reflect on established standards and good practice, but also include the observations we make on the day of the visit, the professional expertise and judgement of our visitors, and what people we met with told us.

We share information with other key scrutiny bodies: the Care Inspectorate (CI), Healthcare Improvement Scotland (HIS) and Her Majesty's Inspectorate of Prisons for Scotland (HMIP). We meet regularly with them and the information shared helps us to decide where we should prioritise our visits.

As well as being published on our website, copies of all our local visit reports are sent to the CI for visits to care homes and to HIS for NHS services and independent hospitals. Copies of our reports on prisons are sent to HIS and HMIP.

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.

Our local visits are not the only time when we visit people in hospitals, care homes and prisons: we often visit at other times during the year to meet with those who are subject to mental health and incapacity legislation. We also carry out national themed visits, where we will visit individuals in similar services across the country and report on our findings.

About our recommendations

When we make recommendations, we allow the service manager 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 to decide if the response is adequate or if we need further information. We check on any future visits to see that the recommendations were implemented as planned.

This visit year we expected an acceptable response to at least 90% of the recommendations we made. We were satisfied that services had responded appropriately to 94% of our recommendations. (We have not yet received responses to 17 recommendations but are following these up with the services concerned).

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 or develop good practice guidance.

This report looks at where we were most likely to make recommendations and what they were about. We also give some examples of where improvements have been made which may be of interest to other services across Scotland.

Where we visited

Table 1: Types of services – number of services visited and recommendations (1 January 2016 to 31 December 2016)

Service Type	Visits		Recommendations	
	No.	%	No.	%
NHS wards for older people, mental health	31	33	131	40
NHS wards, adult mental health	14	15	48	15
NHS wards for adult rehabilitation/continuing care	12	13	46	14
Independent care provider/care homes for older people	7	7	24	7
NHS wards for people with learning disability	6	6	18	5
Prisons	6	6	12	4
NHS forensic psychiatry wards	5	5	12	4
NHS wards for young people, mental health	4	4	7	2
Independent hospitals for young people/mental health	3	3	12	4
Specialist eating disorder units	2	2	9	3
NHS wards acquired brain injury	2	2	2	1
Independent care provider /care homes for people with learning disability	2	2	8	2
Totals	**94**	**100%**	**329**	**100%**

The above table includes nine visits where no recommendations were made.

NHS wards for older people (mental health) were the largest grouping, representing a third (33%) of visits.

The distribution of visits across types of service is broadly similar to last year except for a 50% reduction in the number of visits to care homes. Previously we routinely visited care homes as part of our local visit programme but now only visit where we have discussed with the Care Inspectorate and identified a clear focus for our visit.

We continue to visit individuals in care homes on other visits we carry out, e.g. for individuals subject to incapacity legislation (welfare guardianship).

We also have a themed visit programme, and dependant on where we have chosen to visit, this can influence the number of local visits to a particular types of service over a year. For example, we may decide to visit all adult acute wards as part of our themed visit programme so this will reduce the number of local visits carried out in that year.

Recommendation category

Figure 1: Number of recommendations by category (1 Janurary 2016 to 31 December 2016)

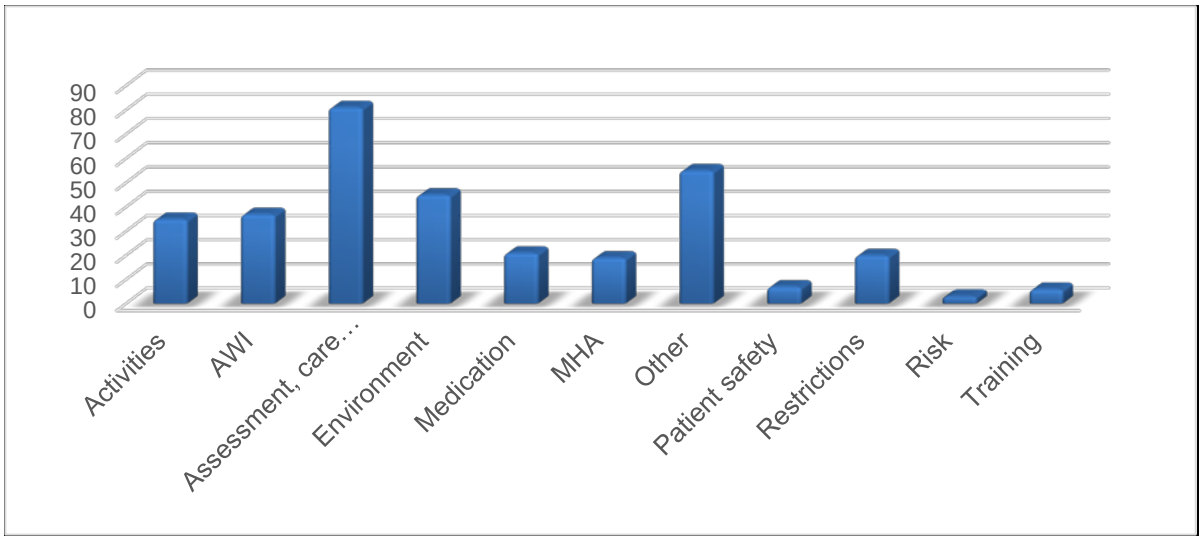

Table 2: Number of recommendations by category (1 Janurary 2016 to 31 December 2016)

Recommendation category	Total	%
Assessment, care planning, review and person-centred care	81	25
Environment	45	14
AWI	37	11
Activities	35	10
Medication	21	6
Restrictions	20	6
MHA	19	6
Patient safety	7	2
Training	6	2
Risk	3	1
Other	55	17
Total	**329**	**100**

The distribution of recommendation category across all recommendations is broadly similar to last year.

Assessment, care planning, review and person centred care

Table 3: Number of recommendations by service type (1 January 2016 to 31 December 2016)

Type of service	Number of recommendations	%
Older people (NHS)	31	38
Adult acute wards (NHS)	13	16
Rehabilitation wards (NHS)	12	15
Older people (private)	5	6
Other services	20	25
Totals	**81**	**100**

This area generated the highest number of recommendations.

Twenty five per cent of all the recommendations we made this year related to assessment, care planning, review and person centred care, the same percentage as last year. These recommendations have been combined for the purpose of this report as they can sometimes be difficult to separate out.

Involvement of the individual in his or her treatment and care is an important principle underpinning the 2003 Act. Care plans are an ideal vehicle to demonstrate that this is occurring. There are many ways of involving the person, even in situations where compulsion is required to ensure treatment is received, or participation appears to be difficult to achieve. For people who have additional needs, it may be necessary to use varying means of communication to support effective participation.

Care plans are a crucial part of supporting and helping the process of recovery. The process of care planning should enable people to take more control of their lives and ensure that the person's perceived needs and aspirations have been taken into account. A good care plan will have the individual, not just his or her symptoms, at the heart of it.

Of these recommendations, 31 related to services for older people. These recommendations were most often about ensuring that care plans were person centred and obtaining and using 'life story' information to help with care planning for people with dementia.

In adult acute mental health wards, the recommendations were mostly about ensuring a recovery focus.
On our visits we want to see that patients are involved and understand their care plan. We carried out a themed visit this year to all adult acute mental health words across Scotland in 2016, and looked further at patients' participation in their care plan.

In all areas, we often highlighted that care plans would benefit from being audited either by peers or managers to ensure the quality of care plans and the documentation that supports them.

Some examples of our recommendations and responses

We recommended:	The service responded:
Managers should review the use of templates in patient care plans and ensure that they are personalised and reflect and inform the care currently being provided.	Although the nursing care plan is a standardised template, the multidisciplinary team have agreed how it should be completed in order to reflect more person centred information. The information noted does now reflect how the ward manages individual distressed behaviours including triggers, signs and methods of de-escalation. The monthly review of care plans continues as well as regular ad hoc review if a change of behaviour is noted. The evaluation of techniques has been built into the review process.
Charge nurse and manager should review care plans to ensure they are individualised and specific goal orientated. Evaluation should be detailed and inform changes to the care plan.	Care plans were audited in August by senior charge nurse and manager. Audit found that some care plans were person centred and goal focussed but not all were. Care plans have been re-written where needed following advice from Senior Charge Nurse. Ongoing Person Centred are planning sessions are being delivered and care plans will be audited again in December 2016.

The two examples above are typical of all the recommendations we made in this category.

Physical environment

Table 4: Number of recommendations by service type (1 January 2016 to 31 December 2016)

Service type	Number of recommendations	%
Older people (NHS)	20	44
Adult acute wards (NHS)	7	16
Rehabilitation wards (NHS)	6	13
Forensic wards (NHS)	4	9
Other services	8	18
Totals	**45**	**100**

This year, 45 (14%) of the recommendations related to aspects of the physical environment where those we visited were living. This is the same percentage as last year.

Some examples of our recommendations and outcomes (continued on next page)

We recommended:	The service responded:
The ward manager should continue to make the ward environment more inviting and improve signage based on the communication needs of the patient group.	Since your visit the ward manager has spoken with colleagues from Speech and Language Therapy and a rolling programme of training has been introduced for all staff to attend as part of the unit's protected learning. We have also introduced signage within the house environments (identifying bedrooms, kitchen, bathroom etc.) and are now looking to introduce menu boards within each area also. Each named nurse identifies any further communication needs on admission and individual areas (mainly signage in bedrooms) can be adapted to suit individual needs.

Managers should consider how to make the ward a less clinical environment within infection control guidelines.	The clinical team, patients and other staff are disappointed and surprised that the MWC felt that the area was both clinical and bland. There have been many visitors to the unit who have complemented both the staff and patients for making the environment safe, therapeutic and aesthetically pleasing. We have to bear in mind that this is a secure facility and adhere to national low secure standards. Despite this, the senior charge nurse along with staff and patients looked at ways to introduce a more homely feel. They purchased scatter cushions, bean bags and have purchased some canvases to go on the walls. I have also asked our advanced practitioner occupational therapist to consult with the community initiative who have an art therapist to review ways we could make the environment less bland. This would be done in consultation with the patient group and taking into account the need for adherence to infection control and fire safety.

Adults with Incapacity (Scotland) Act 2000

Table 5: Number of recommendations by service type (1 January 2016 to 31 December 2016)

Service type	Number of recommendations	%
Older people (NHS)	16	43
Older people (private)	9	24
Young People (private)	2	6
Other services	10	27
Totals	**37**	**100**

We want to know that people are receiving treatment in line with the law, particularly in relation to Part 5 of the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act); this Act provides important safeguards for people.
Eleven per cent of all our recommendations related to the 2000 Act; the majority to services for older people both in care homes and hospitals. This is a slight increase on last year where 10% of all recommendations made related to the 2000 Act.

The majority of recommendations we made in this category related to making sure that those with proxy decision making powers (powers of attorney and guardians) were clearly identified in care notes along with the powers granted.

The Commission has produced guidance notes for staff working with the Adults with Incapacity Act in care homes[1] and has published guides specifically on the subject of power of attorney.

Some examples of our recommendations and outcomes

We recommended:	The service responded:
Managers should ensure all staff are aware of and understand the effects of a welfare guardian or power of attorney having been appointed as a proxy decision maker. Nursing staff should be aware of the necessity for production of copies of this legal paperwork and this should then lead to a discussion re delegation of powers which should be recorded in the notes.	Training is being delivered from an MHO for staff within the ward in relation to POA. Information has been provided to all staff for them to read and sign off to demonstrate they understand the legalities relating to POA. A process is now in place for staff to request a copy of the POA certificate for filing in nursing notes.

[1] Working with the Adults with Incapacity Act: Information and guidance for people working in adult care settings (2007) http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf

Therapeutic Activity

Table 6: Number of recommendations by service type (1 January 2016 to 31 December 2016)

Service type	Number of recommendations	%
Older people (NHS)	14	40
Rehabilitation wards (NHS)	8	23
Adult acute wards (NHS)	4	11
Older people (private)	3	9
Other services	6	17
Totals	**35**	**100**

Thirty five of the recommendations made this year concerned the provision of therapeutic activity, 10% of all recommendations made. This is similar to last year's findings.

Activity and occupation should be viewed as an essential part of care and treatment and not an optional extra, particularly when people are in hospital or care home for an extended period of time.

Of these recommendations, just under half related to services for older people, both in NHS wards and private care homes. These tended to relate to a lack of recording of participation in and the outcome from any activity.

Some examples of our recommendations and outcomes (continued on next page)

We recommended:	The service responded:
The charge nurse and manager should ensure that individualised person centred activities as well as group activities, are available both on and off the ward for all patients.	We have identified a vacant nursing assistant post that we have converted to an activities coordinator role for the ward. We aim to have someone in post in Nov. In the meantime we have been able to ring fence a nursing assistant role to specifically work on the individual

	and group therapeutic activities both in and off the ward.
Individual activity planners should be reviewed and include all the therapeutic, educational, social and recreational activities that are contributing to the patient rehabilitation programme.	Staff have been encouraged to ensure that each patient has an individual activities planner which accurately reflects all the therapeutic activities carried out by the patient. The accurate recording of activities attended off the ward, such as recreational therapy, has been encouraged with staff being asked to include the activity carried out. The importance of including daily living tasks such as self-care and tidying their rooms etc. as an activity, has also been reinforced with staff, for some of the patient group the successful completion of these activities can be seen both as an achievement and an intervention.

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

Table 7: Number of recommendations by service type (1 January 2016 to 31 December 2016)

Service type	Number of recommendations	%
Older people (NHS)	7	37
Adult acute wards (NHS)	4	20
Eating Disorders	3	16
Rehabilitation wards (NHS)	2	11
Other services	3	16
Totals	**19**	**100**

Nineteen (6%) of our recommendations concerned the Mental Health (Care & Treatment) (Scotland) Act 2003 (The Act). This is a reduction from seven per cent of all recommendations made last year. Older people (NHS) wards accounted for 37% of all recommendations made in relation to the Act.

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 local 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 check to make sure that no one we visit is subject to unauthorised deprivation of liberty and those who are subject to the Act have all the necessary safeguards in place, including completion of required documentation.

Some examples of our recommendations and outcomes

We recommended:	The service responded:
Managers should keep an index of mental health act documentation with dates indicating when reviews are due and introduce regular audit of these.	There is now a system in place where secretarial staff keep a live record of all detention paperwork including review and renewal dates. This is issued to medical staff, Senior Charge Nurse and to the nursing staff and a copy displayed in the nursing office for all staff to be aware of.
Managers should ensure that senior nursing and medical staff are clear about specified persons procedures.	Clinical director will ensure all psychiatrists (including trainees) are reminded of the specified person's procedure and share the link in the MWC report to ensure good practice.

Most of the recommendations in this category related to ensuring compliance with documentation for specified persons, suspension of detention and consent to treatment provisions of the Act. We will also write directly to responsible medical officers to raise issues about individual patients and use of legislation as it may breach a patient's confidentiality to highlight in our published report.

The Commission has produced good practice guidance on these provisions.

Medication

Table 8: Number of recommendations by service type (1 January 2016 to 31 December 2016)

Service type	Number of recommendations	%
Older people (NHS)	7	34
Adult acute wards (NHS)	4	19
Rehabilitation wards (NHS)	4	19
Older people (private)	3	14
Other services	3	14
Totals	**21**	**100**

Some examples of our recommendations and outcomes

We recommended:	The service responded:
Managers should ensure that intramuscular “if required” psychotropic medication is not prescribed for informal patients, other than in exceptional individual circumstances. This recommendation was escalated to the Associate Medical Directors to take forward.	A request was made to the mental health pharmacist who regularly provides induction for junior doctors on rotation to Mental health to ensure best practice is communicated at the beginning of the rotation. All senior charge nurses have cascaded to the nursing teams that this is not recommended good practice.

The majority of recommendations relating to consent to treatment are included in the MHA and AWI categories, but we did record several recommendations related to the prescription of medication, particularly intramuscular medication, prescribed on an as required basis.

Further action

The continuing high number of recommendations we make about care planning, review and person centred care

This correlates with our findings from a themed visit to adult acute admission wards in 2016/17 and was an area of focus. We recommended in our report that NHS health boards should review their care planning documentation to ensure it is recovery focused and promotes patient participation.

We also recommended that health boards should ensure Scottish Recovery Indicator 2(SRI2) action plans are implemented. We found that in areas where these had been implemented, we were more likely to find recovery focused care plans and higher levels of participation.

We will continue to review care plans and participation on all our local visits.

We will also liaise with key stakeholders to consider how to promote best practice in relation to care planning.

Deciding whether a response to our recommendations is acceptable

We are introducing a new process for how we manage responses to our recommendations.

We are doing this because we want to be as sure as we can that our recommendations are being implemented.

We are planning on providing service managers with clear guidance about what they need to include in their response. We are providing our staff with clear guidance about what needs to be done before we consider a response acceptable and ensuring a consistent approach to this.

We will consider the level of follow up that is required with the service dependant on the nature of the recommendation and the service's response.

This may initially lead to a fall next year in the number of recommendations that we consider to be acceptable but we want to be sure that we are reporting accurately and robustly following up on our recommendations.