mentalwelfare commission for scotland

VISIT AND MONITORING REPORT

Recommendations and outcomes from our local visits 2015

July 2016

RECOMMENDATIONS AND OUTCOMES FROM OUR LOCAL VISITS 2015

About the Commission

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

We do this by

- Checking if individual care and treatment are lawful and in line with good practice
- Empowering individuals and their carers through advice, guidance and information
- Promoting best practice in applying mental health and incapacity law
- Influencing legislation, policy and service development

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.

Our local visits

One way of achieving the above is by local visits to 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 1st January 2015 and 31st December 2015 we carried out 108 local visits and we made 409 recommendations relating to these visits.

We recently reviewed our annual visits programme and are committed to continuing with our local visits but with some changes.

From December 2015, we started publishing local visit reports from NHS services on our website. Publication of care homes, prisons and independent hospital reports begins on 1st June 2016.

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 though take into account any applicable national standards and good practice guidance. Our findings and the recommendations we make will reflect on established good practice as appropriate(such as national care standards, dementia standards for Scotland) 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 are improving our communication and information sharing 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 we share 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 to 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 then 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 will 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 97 % of our recommendations. (We have not yet received responses to 12 recommendations but are following these up with the services concerned).

We believe this demonstrates our effectiveness in influencing service improvements through a targeted, risk based programme of local 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 or develop good practice guidance.

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

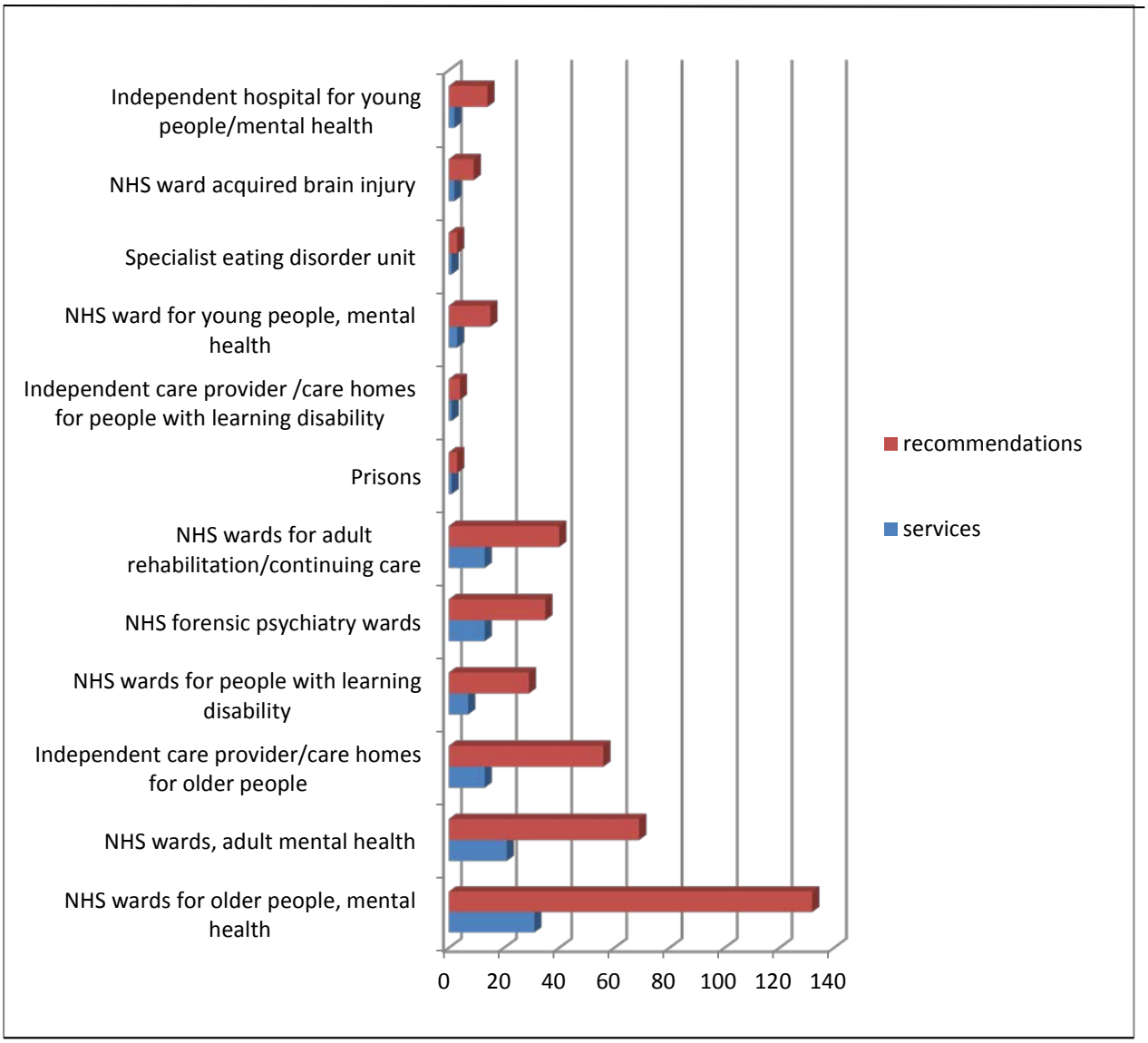
Where we visited

Types of services – number of services visited and recommendations (1st January 2015 to 31st December 2015)

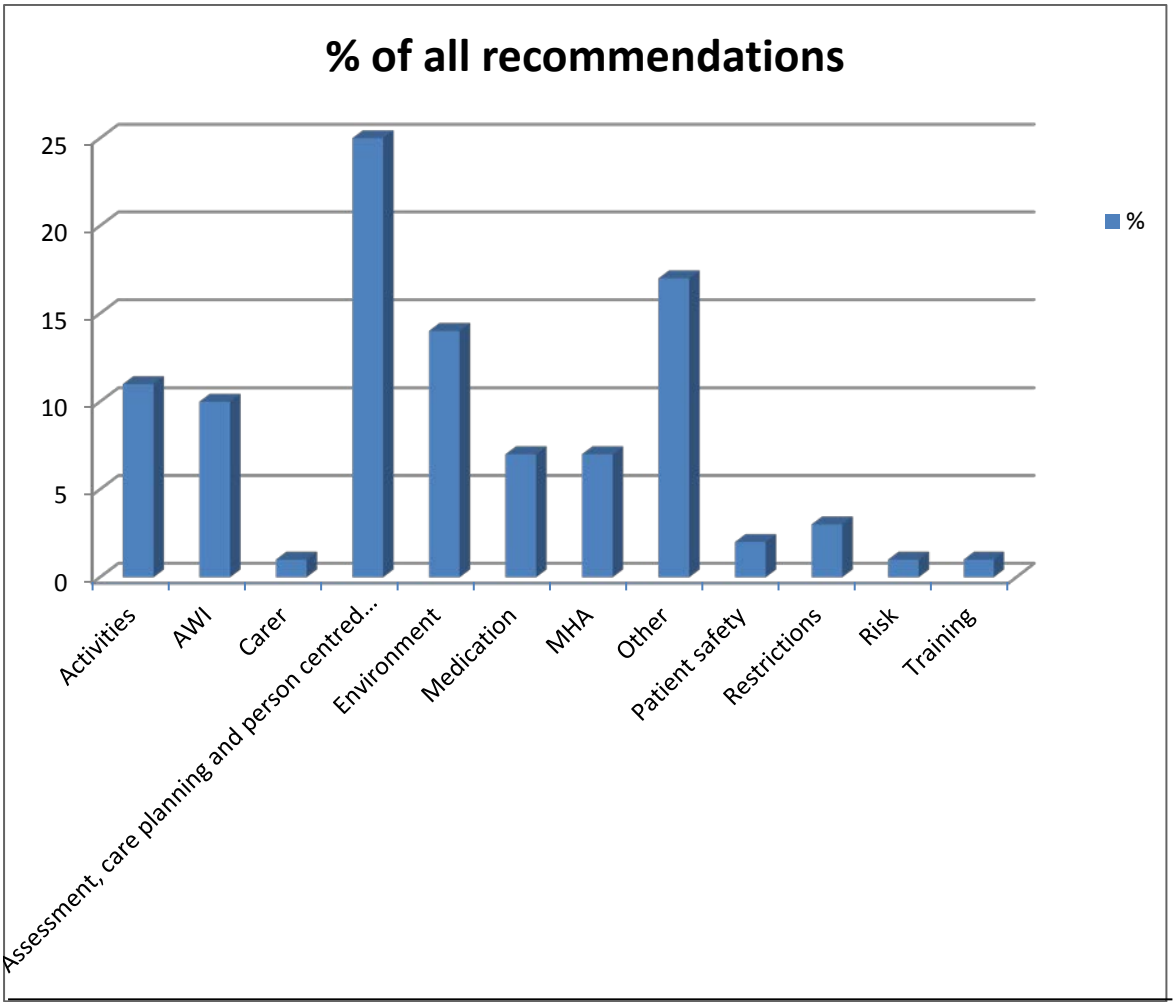
Service Type	Services		Recommendations	
	No.	%	No.	%
NHS wards for older people, mental health	31	29	132	32
NHS wards, adult mental health	21	19	69	17
Independent care provider/care homes for older people	13	12	56	14
NHS wards for people with learning disability	7	6	29	7
NHS forensic psychiatry wards	13	12	35	8
NHS wards for adult rehabilitation/continuing care	13	12	40	10
Prisons	1	1	3	1
Independent care provider /care homes for people with learning disability	1	1	4	1
NHS ward for young people, mental health	3	3	15	4
Specialist eating disorder unit	1	1	3	1
NHS ward acquired brain injury	2	2	9	2
Independent hospital for young people/mental health	2	2	14	3
Totals	**108**	**100%**	**409**	**100%**

The above table includes five visits where no recommendations were made.
NHS wards for older people mental health were the largest grouping, representing over a quarter (29%) of visits, generating the majority of recommendations over the visit period.

Number of services visited and number of recommendations made



Recommendation category



Recommendation category	Total
Activities	46
AWI	42
Carer	2
Assessment, care planning, review and person centred care	101
Environment	59
Medication	29
MHA	30
Other	70
Patient safety	9
Restrictions	14
Risk	4
Training	3
Total	**409**

Assessment, care planning, review and person centred care:

Type of service	Number of recommendations	%
Older people (NHS)	36	35
NHS Adult acute wards	15	15
Older people (private)	13	13
Other services	37	37
All services	101	100

This area generated the highest number of recommendations.

25% of all the recommendations we made this year related to assessment, care planning, review and person centred care, a slight increase (4%) on 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, the majority (49) 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 are carrying out a themed visit this year to all adult acute mental health words across Scotland and will be looking further at patient's 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
There should be a review of care planning procedures to ensure that all individuals have person-centred care plans that are fully reviewed and evaluated regularly.	Charge Nurses audited multidisciplinary notes to review what we were currently doing, and identify good person-centred and client led care planning and recording of keyworker 1:1 input All trained staff to seek examples of good practice to bring to a care planning workshop– to look at examples of good practice, decide on a format for the ward and trial this for eight weeks to make sure care planning is person-centred, fully reviewed and evaluated regularly.
Senior nurse to arrange for the care plans to be reviewed to reflect the nursing intervention, which should include evidence in patient's participation in their own care.	Arrangements are now in place for the Charge nurse and depute charge nurse to witness the care plans being signed by the patient, the keyworker and a senior nurse. Hope is that this will now reflect the high standards of care, treatment and support as well as being more individualised and personalised for patients.
Managers should ensure that care plans are person centred and reflect the needs, interests, abilities and preferences of the individual. Care plans for the management of stress and distress should contain detailed information on the individual behaviours, the triggers for these, and the management strategies to be used.	The Practice Development Nurses will deliver training sessions to named nurses to enhance care planning skills. Staff to support patients and carers in filling out 'Getting to Know Me' information on admission. Weekly meetings currently take place with regards discussion, planning and implementing individually tailored care plans around stress and distress

Physical environment:

Service type	Number of recommendations	%
Older people (NHS)	17	29%
NHS adult acute wards	11	19%
NHS Learning Disability	9	15%
Other services	22	37%
All services	59	100%

This year, 59 (14%) of the recommendations, related to aspects of the physical environment where those we visited were living. This is a lower number than last year when the physical environment accounted for 19% of all recommendations.

Whilst the overall number of recommendation made in NHS wards for older people has remained about the same as last year there has been a decrease in the recommendations made in adult acute wards, including Intensive Psychiatric Care Units (IPCUs). From 29% of all recommendations made last year to 19% this year.

We have seen some improvements across the country with some new build hospitals of a very high standard .e.g. Midpark hospital. We do though continue to visit some wards where similar conditions in a general hospital setting would not be tolerated.

Some examples of our recommendations and outcomes:

We recommended	The service responded
The ward would benefit from the provision of artwork in the family room, lounges and corridors.	This has now been installed and within the boundaries of HEI standards we will continue to strive to make the ward as aesthetically pleasing as possible for the benefit of patients, visitors and staff.
Service and ward manager should make provision for a safe and appropriate place for patients to meet with their children.	An area within the ward has now been refurbished to provide a dedicated family room where patients can meet with their children in a safer environment.
Managers should address the poor shower facilities for females as soon as possible, and look again at the provision of the bath within the male corridor	Substantial work has just been completed in the ward. This includes the provision of a bath and shower area in the female corridor and the previous laundry room has also been changed to accommodate two toilet cubicles nearby.

Therapeutic Activity

Service type	Number of recommendations	%
Older people (NHS)	15	32
Older people (private)	5	11
NHS Adult acute wards	9	20
Other services	17	37
All services	46	100

46 of the recommendations made this year concerned the provision of therapeutic activity, 11% 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 general lack of activities, a lack of recording of participation in and the outcome from any activity. These were broadly similar to the recommendations made in adult acute and other services.

Some examples of our recommendations and outcomes:

We recommended	The service responded
Every individual should have an opportunity to participate in activities which provide them with a meaningful day. This needs to be seen as part of the core responsibility of all staff and training provided where required to support this	Staff have been issued with the care inspectorate "make every moment count" publication and in house training is being carried out to assist staff to better engage clients in meaningful activity. Volunteers are now involved in assisting staff in provision of activities. A new activity coordinator is in place
The Commission recommends there should be a system for auditing and responding, when activities or outings have to be cancelled because of staffing issues.	Information now collected at ward level on when and why activities are cancelled. Reports will be compiled from this and discussed and actioned at Clinical Governance Group.

The provision of therapeutic and recreational activities is an important aspect of care. There needs to be a review of the provision of individual and group activities to ensure that patients are supported to engage in a range of activities to suit their needs	Ward has undertaken a review of the existing activity programme; this review involved patient views, staff views and MDT team views. We explored ways of improving meaningful activity again based on a holistic recovery focussed approach. We are in the final stages of rolling out our revised programme of activities; these activities can be delivered both in a group setting or individually on a 1:1 basis. There will be a ward timetable which the patient group will contribute to, to ensure group activities are meeting the needs of the patient population on a week to week basis.

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

Service type	**Number of recommendations**	***%***
Adult acute (NHS)	7	23
Older people (NHS)	8	27
NHS forensic	6	20
Other services	9	30
All services	30	100

30 (7%) of our recommendations concerned the Mental Health (Care & Treatment) (Scotland) Act 2003(The Act). This is a reduction from 13% of all recommendations made last year. Adult acute admission wards accounted for 23% 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.

This year we picked up on some common errors made with cross border transfer of patients into Scotland and some independent providers not being fully conversant with Scottish mental health and incapacity legislation. We have been liaising with the providers, Healthcare Improvement Scotland and the Care Inspectorate to address this.

Some examples of our recommendations and outcomes:

We recommended	**The service responded**
RMO's should ensure that consent to treatment is clearly and correctly recorded within the appropriate timescales to ensure that there is adequate information to evidence consent.	All medical staff has been reminded of the importance of making requests for second opinions for consent and treatment within the appropriate time scales. In addition the MHA administrators provide prompting to the medical staff for either T2/T3.This will be a regular agenda item at the Clinical Management team meeting, and subject to regular audit.
The RMO should ensure that forms authorising treatment are in place where required to authorise treatment under the Mental Health Act.	Response: Clinical Director has fully discussed with the medical team the need to be fully cognisant of requirements for Treatment Authorisation (T2/3) Forms to be completed in accordance with legislation and regulation at all times.
Manager should ensure staff access training on Scottish legislation to broaden their knowledge and understanding.	Manager will remove all English Legislation from the care plan documentation, staff will continue to input Scottish legislative in the meantime. All MWC documentation regarding legal requirements and Scottish legislation have been made available to all staff including EG: Common concerns with power of attorney, consent to treatment

Adults with Incapacity (Scotland) Act 2000

Service type	Number of recommendations	%
Older people (private)	17	40
Older people (NHS)	18	43
Other services	7	17
All services	42	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.

10% of all our recommendations related to the 2000 Act; the majority to services for older people both in care homes and hospitals. This is another reduction on last year when 12% of all recommendations made related to the 2000 Act and 16% in 2013.

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 .These can be found at *insert link*.

Section 47 of the Act authorises medical treatment for people who are unable to give or refuse consent to medical treatment. Under section 47 a doctor or other authorised healthcare professional examines the person and may issue a certificate of incapacity.

The certificate is required by law and provides evidence that treatment complies with the principles of the Act. Around 26% of the recommendations we made in this category related to section 47 certificates, a reduction from 37% last year and 50% in 2013.

[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

Some examples of our recommendations and outcomes:

We recommended	The service responded
Where there is a proxy in existence, this should be indicated prominently within the live file and there should be a record of contact details and the powers held. A checklist which supports this can be found on our website.	Where there is a proxy in place, this is now recorded at the front of the care plan along with a completed AWI checklist
It should be ensured that S47 certificates/treatment plans are completed in accordance with the code of practice and cover all medical treatment the individual is receiving that they are not capable of consenting to	Following guidance from MWC we have been reviewing and renewing all our S47 certificates/treatment plans to ensure that they comply with the code of practice

Further action

Looking at the recommendations we made this year.

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

We are planning a themed visit to adult acute admission wards in 2016/17 and this will be an area of focus.

- **The recommendations we make in relation to compliance with Part 16 of the Act and prescribing practice.**

We will continue to review the treatment plans for those we meet who are subject to Part 16 of the act and raise any concerns with appropriate RMOs.

- **The recommendations we make in relation to the physical environment.**

We have commented in previous reports on the lack of suitable visiting space for children who visit their parents in adult acute admission wards and this was again identified in this report. This will be an area of focus on our themed visit to adult acute admission wards in 2016/17.

- **The recommendations we make in care homes and hospitals about recording key information on those who have a welfare power of attorney /guardian and their powers**.

We will continue to work closely with the Care inspectorate and Healthcare Improvement Scotland to improve this.

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809
enquiries@mwcscot.org.uk
www.mwcscot.org.uk

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