mentalwelfare commission for scotland

VISIT AND MONITORING REPORT

Recommendations and outcomes from our local visits 2014

Summary of recommendations and outcomes from our local visits 2014

July 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 2014 and 31st December 2014 we carried out 125 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.

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 are meeting regularly with them and the information we share helps us to decide where we should prioritise our resources.

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 check on any future visits to see that the recommendations were implemented.

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 99.6 % of our recommendations. (We have not yet received responses to two 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.

Copies of all our 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.

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.

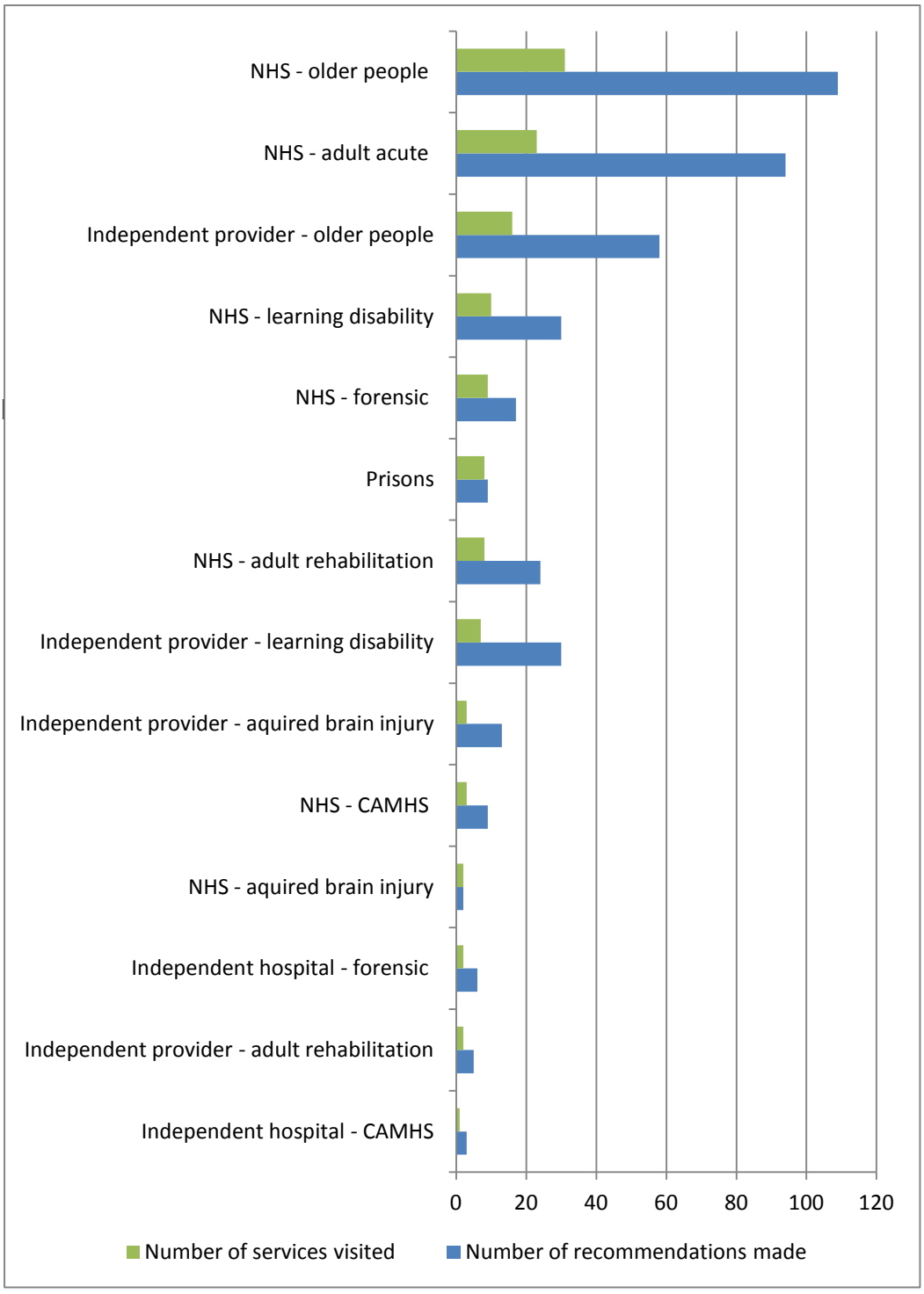
Where we visited

Types of services – number of services visited and recommendations (1st January 2014 to 31st December 2014)

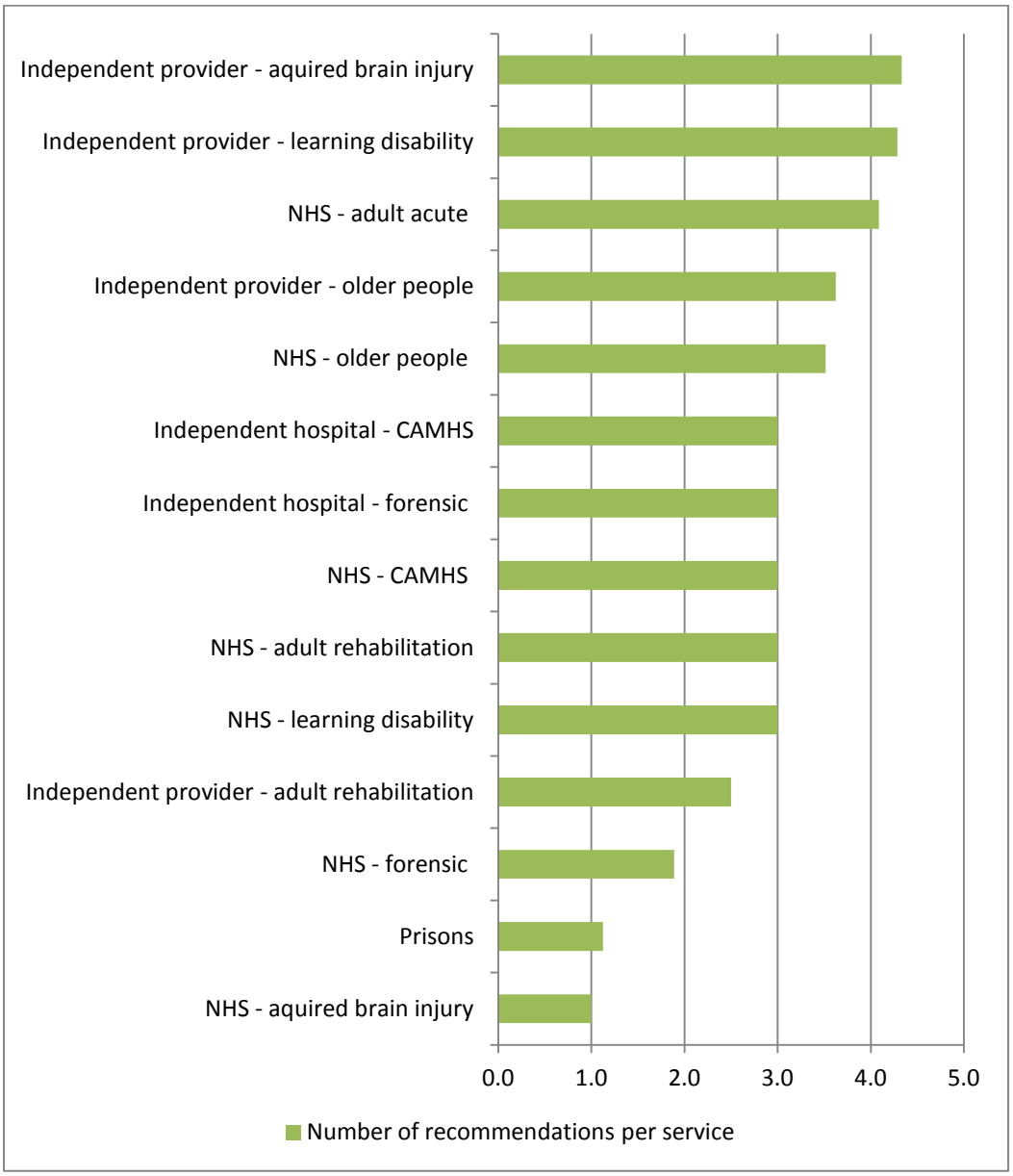
Service Type	Services		Recommendations	
	No.	%	No.	%
NHS wards for older people, mental health	31	25	109	27
NHS wards ,adult mental health	23	18	94	23
Independent care provider /Care homes for older people	16	13	58	14
NHS wards for people with learning disability	10	8	30	7
NHS forensic psychiatry wards	9	7	17	4
NHS wards for adult rehabilitation/continuing care	8	6.5	24	6
Prisons	8	6.5	9	2
Independent care provider /care homes for people with learning disability	7	6	30	7
Independent care provider/care homes for adult rehabilitation/continuing care	2	1.5	5	1
NHS ward for young people, mental health	3	2.5	9	2
Independent care provider/care home acquired brain injury service	3	2.5	13	3
Independent hospital forensic psychiatry wards	2	1.5	6	1.5
NHS ward acquired brain injury	2	1.5	2	0.5
Independent hospital for young people/mental health	1	Less than 1%	3	1
	125	100 %	409	100%

The above table Includes 11 visits where no recommendations were made.
NHS wards for older people mental health were the largest grouping, representing a quarter (25%) of visits, generating the majority of recommendations over the visit period.

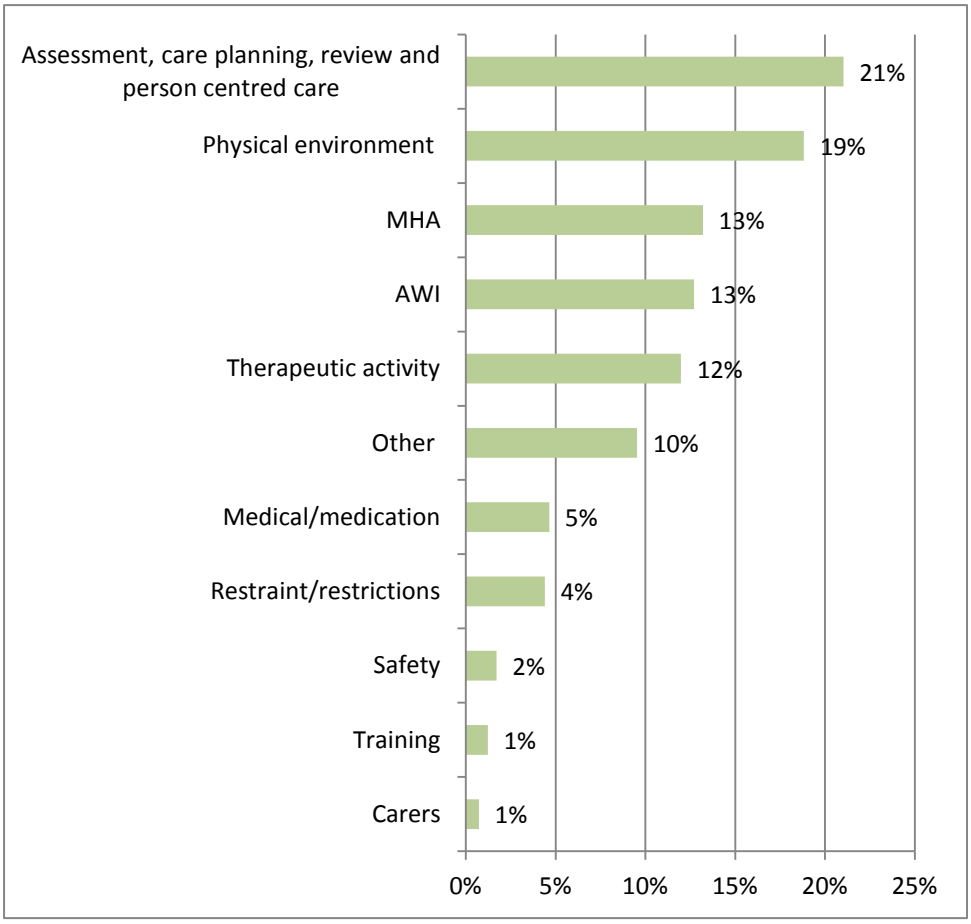
Number of services visited and number of recommendations made.



Number of recommendations per service



Recommendation category (% of all recommendations)



Assessment, care planning, review and person centred care:

Service type	Number of recommendations	%
Older people (NHS)	25	29
NHS adult acute wards	18	21
Older people (private)	9	10
Other services	34	40
All services	86	100%

As was the case last year, this area generated the highest number of recommendations.

21% of all the recommendations we made this year related to assessment, care planning, review and person centred care. These recommendations have been combined for the purpose of this report as they can sometimes be difficult to separate out.

Of these recommendations, the majority (25) 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 wards the recommendations were mostly about ensuring a recovery focus and that care plans were regularly reviewed and audited by mangers to ensure the quality of care plans and the documentation that supports them.

In other services the recommendations were broadly similar and focussed on ensuring individual’s participation in planning and reviewing their care.

By person centred care we mean providing care that is responsive to individuals’ personal preferences, needs and values. In relation to older people, this is the term that we find is most commonly used and understood.

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.

Some examples of our recommendations and outcomes.

We recommended	**The service responded**
We recommend that aids to communication such as pictorial care plans are used where appropriate to increase the involvement of service users in their care plans.	*Work has commenced with Speech and Language Therapy staff to produce a fully accessible care plan for patients. Staff are currently providing feedback from Care Programme Approach meetings in an accessible format.*
We recommend that where appropriate, care plans are prepared in a format which will be accessible to each individual person, to encourage their participation in decisions about their care and treatment.	*The care plans within x are not at present in a patient friendly format. The nursing staff have been using the new electronic care plans. However, these are proving to be inappropriate for our patient group. Charge nurse is leading a ward improvement plan, which will now include how patients can have copies of their care plan in a user friendly and meaningful format.*
The documentation in the PSDPs needs to be reviewed and streamlined; outdated, undated or repetitive information needs archived; and the essential aspects of providing consistent support to an individual should be clear to all members of staff. This includes the risk assessments, support plans and behaviour plans.	*Monthly audit & review enacted to allow continuous learning.*

Physical environment:

Service type	Number of recommendations	%
NHS adult acute wards	22	29%
Older people (NHS)	21	27%
Older people (private)	8	10%
NHS adult rehabilitation	7	9%
Other services	19	25%
All services	77	100%

77 of the recommendations, 19% of all recommendations made this year, related to aspects of the physical environment where those we visited were living. This is a higher number than last year when the physical environment accounted for 13% 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 an increase in the recommendations made in adult acute wards, including Intensive Psychiatric Care Units (IPCUs). From 21% of all recommendations made last year to 29% this year.

In adult acute wards and IPCU's, the recommendations related mostly to general maintenance that was required within the wards, having easy access to safe and pleasant outdoor space and concerns about a lack of compliance with no smoking rules. In three adult acute wards we recommended that space was made available to allow younger children to visit their parents.

A common theme in services for older people was that we thought the environment was not dementia friendly or enabling, this echoes our findings in the last two visit years. This was mainly in relation to inadequate signage and lack of personalisation in bedroom areas.

We continue to hear from staff that they particularly welcome our recommendations when these relate to estates departments in hospitals as they find this helpful in making sure the work is carried out. We do not think it is acceptable that often it requires our intervention before works are carried out, where it is clearly evident that such works are required and have already been requested.

Some examples of our recommendations and outcomes.

We recommended	The service responded
Managers should review the physical environment in X and encourage individuals, where possible, to personalise their rooms. They should also look at how the standard seen in X can be provided for all residents.	*Audit tool devised for audit of bedrooms to identify specific rooms and prioritise individualising of these where possible. Key workers in unit to support individuals to personalise their rooms. Environment of unit reviewed and request for funding re items of furniture submitted. Lighting is under review by maintenance manager; however report will be flagged up to him.*
Managers should consider the benefits which may be gained by having a cafe in the hospital for the use of all individuals and visitors who may have travelled some distance to be there.	*A project proposal has recently been approved to support development of a Cafe which will be located within the main reception area. This new facility will be accessible to service users, visitors and staff. Development works are hoping to commence early in the New Year.*
There should be a review of the building in terms of its layout and fabric to ensure it is fit for purpose in terms of patient safety and the provision of a therapeutic environment for the care and treatment of people who have a range of mental health, behavioural and sensory problems.	*There has been recent upgrading of most of the environment, including refurbishment of a number of en-suite bathrooms and the ADL Kitchen.* *The development of individual activity planners has helped to reduce the noise levels in certain areas of the ward.* *There is no longer a de-escalation room; individuals can be supported in another quite low stimulus area off the ward if needed.*
Consideration should be given to more personalisation in bedrooms.	*The use of white boards in patients bedrooms have been introduced to provide prompts in relation to patient care. Families are being encouraged to provide small personal items for individual patient bedroom; the ward has also purchased soft furnishings for bedrooms.*
Managers should make provision for a safe and appropriate place for parents to meet with their children.	*Dr x indicated that the Consultants would be willing to give up their office space in ward to create a family room. We are actively looking at how this can be accommodated and I have discussed this with the Operation manager*.

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

Service type	Number of recommendations	%
Adult acute (NHS)	20	37
Older people (NHS)	12	22
NHS forensic	5	9
Other services	17	32
All services	54	100

54 of our recommendations concerned the Mental Health (Care & Treatment) (Scotland) Act 2003(The Act). This is a rise from 8% of all recommendations made last year to 13% this year.

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 de facto detention and that those who are subject to the Act have all the necessary safeguards in place, including completion of required documentation.

Adult acute admission wards accounted for 37% of all recommendations made in relation to the Act.

Of our recommendations in adult acute wards, just over 50% of these related to part 16 of the Act which involves medical treatment. We recommended that improved procedures were put in place to ensure patients received treatment in line with the requirements of the Act.

This was also the case in NHS wards for older people with Part 16 issues accounting for 50% of the recommendations made.

We made recommendations in five services where we came across the practice of prescribing as required intra muscular (IM) medication for agitation for informal patients. We think it unlikely that an informal patient requiring IM medication for extreme agitation would be giving valid consent to this.

The other recommendations made across all services related to incomplete safety and security documentation, suspension of detention and general recommendations about the management of MHA documentation.

The Commission provides good practice guidance on many of these subjects and can be accessed via our website[1].

Some examples of our recommendations and outcomes.

We recommended	The service responded
Request for DMP visits for T3's must be submitted in sufficient time to ensure that treatment continues to be administered in keeping with Part 16 of the Act.	*All Consultants are reminded timeously about the need to submit requests by our administrative staff. This report was also shared with our Associate Medical Director to encourage compliance and a reminder was issued to medical staff.*
Managers should ensure that individuals subject to enhanced observations, who are not subject to detention under the Mental Health Act, are made aware that staff have no authority to limit their time spent outwith the ward other than with their agreement.	*Individuals who are not subject to the Mental Health Act yet subject to enhanced levels of observation will be clearly informed of their rights as informal patients. This will be documented within the nursing notes.* *All individuals subject to enhanced levels of observation will be provided with written information explaining enhanced levels of observation. There will be recorded information in nursing notes of joint discussion and agreement reached regarding limitation of time spent out with the ward.*
RMOs and ward managers review an individual's status when they are being subject to restrictions which should be authorised under Section 286 of MH(S) A to ensure that individual's rights are being upheld. In addition, managers must ensure that staff have appropriate training in this area.	*A specified person policy has been written and there will be training to ensure all staff groups involved in patient care is familiar with the rights of individuals and ensure that they are acting in the interests of the patients. There has been training for nurses. Other staff groups will be included in training.*
RMO's and nursing staff review the status of individuals who are subject to detention and are required to provide urine/breath samples for testing and that they are designated specified persons.	*Guidance on specified persons for nursing staff is almost complete and will be available shortly. In the interim, Nursing staff will remind RMO's of the requirement to consider whether patients require specified persons status.*

[1] http://www.mwcscot.org.uk/publications/

Adults with Incapacity (Scotland) Act 2000

Service type	Number of recommendations	%
Older people (private)	21	40
Older people (NHS)	14	27
Other services	17	33
All services	52	100

12% of all our recommendations related to the Adults with Incapacity (Scotland) Act 2000 (the 2000 Act); the majority to services for older people both in care homes and hospitals. This is a reduction on last year when 16% of all recommendations made related to the 2000 Act.

Last year 83% of these recommendations were made in services for older people both in care homes and hospitals.This has reduced to 67% this year.

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

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

Around 37% of all recommendations in this category related to the lack of section 47 certificates and treatment plans where we felt they should have been in place or where they were in place but not being completed properly. This is a reduction on almost 50% last year.

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

Of the other services where we made recommendation related to the 2000 Act, these were mainly in care home services for people with learning disability, acquired brain injury and alcohol related brain damage. Around half of these related to section 47 certificates and the rest in relation to a lack of knowledge or documentation for welfare guardianship or welfare power of attorney.

The Commission has produced guidance notes for staff working with the Adults with Incapacity Act in care homes[2] and will be publishing quick guides specifically on the subject of power of attorney in summer 2015.

Some examples of our recommendations and outcomes.

We recommended	The service responded
We recommend to the managers in both units that the checklist which the Commission has included in our good practice guidance, working with the Adults with Incapacity (Scotland) Act, is used and is kept in individual files. A copy of this good practice guidance was sent to the service after our visit.	*The good practice guidance has been received and is currently being utilised in all relevant personal files.*
The managers of the service should contact the relevant GP surgery to establish if there are Section 47 certificates in place, where required, and discuss the possibility of holding a copy within residents case files.	*Records checked for presence of section 47 certificates. Relevant GP contacted for those with missing or out of date certificates. Certificates are now in place and we are compliant.*
When a welfare proxy is in place for a patient, a copy of the document stating the powers of the proxy should be held within the case notes.	*We now use the legal status form to record POAs, Guardianships etc. The nursing staff will sign when they have asked for a copy of the document and sign when we have received a copy and it is in the medical notes.*
Where residents are getting covert medication, a covert medication pathway should be completed and this should be regularly reviewed.	*The day after the visit, a covert Medication Pathway was completed for the gentleman who can receive his medications covertly if necessary.*

[2] Working with the Adults with Incapacity Act: Information and guidance for people working in adult care settings (2007)

Therapeutic Activity

Service type	Number of recommendations	%
Older people (NHS)	18	37
Older people (private)	9	18
NHS Adult acute wards	7	14
Other services	15	31
All services	49	100

49 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.

Of those recommendations, just over half related to services for older people, both in NHS wards and private care homes.

These tended to be about providing more opportunities for residents to participate in physical, social and recreational activities both in the unit and in the community.

Of the other services, half were distributed evenly across NHS and independent learning disability services. These tended to have more of a focus on activities based on individual ability, interests and mental health needs, including regular opportunities to use community resources.

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

Some examples of our recommendations and outcomes.

We recommended	The service responded
Therapeutic activities provision in x should be reviewed with a view to increasing this.	*We have carried out work within the nursing team to identify periods of time within the day when therapeutic activities can be carried out. A small working group headed by a staff nurse with particular interest in this area are now identifying suitable activities to fill the time slots allocated. We would hope to have a minimum of at least 1 activity per morning and afternoon and then extend this to evening times.*
The provision of a programme of meaningful activities should be a core element of care planning and activity plan and record of participation and outcome for each individual.	*A training programme has been devised and commenced in conjunction with community Psychiatric Team leading the training. Now that staff have completed their training, the next part of the process which is completing the assessment has been commenced. it is envisaged that all assessments will be completed by the middle of December. Thereafter and individual activity plan with pictorial aid will be developed and put in place.*
Each patient should have a weekly programme of activities, based on their interests and mental health need, which are recorded and audited to ensure they take place.	*The SCN will meet with the named and associate nurses to implement this recommendation. A delegated senior member of the ward team will be responsible for auditing systems that are put in place.*
Utilisation of activities room should be addressed immediately.	*The activities room was deep cleaned and tidied up immediately following your visit. Quiet room has been converted to a reminiscence room. A varied range of activities have been scoped and equipment purchased.*

Access to medical care and treatment

Service type	Number of recommendations	%
NHS Adult acute wards	6	32
NHS Learning disability	2	11
Older people (private)	2	11
Other services	9	46
All services	19	100

19 of the recommendations we made concerned medication and access to medical care and treatment, 5% of all recommendations made.

Around a quarter of these recommendations were in relation to prescribing practices for as required medications; often these did not stipulate dosage intervals or maximum dosages which is a patient safety concern.

Other recommendation made across all services included ensuring access to physical health screening, GP and pharmacy services.

We recommended	**The service responded**
NHS x should make arrangements to ensure that individual patients who are not registered with a GP are included in all relevant national screening programmes.	*Links made with primary care to access national mammogram screening programme for female patients. Redesign of rehab service will look at possibility of GP sessions to supplement workforce model and in addition to all patients being registered with a GP.*
The manager should check that the GP is carrying out annual health checks on those individuals who require them and that there is a record of this kept on file for reference.	*New proforma has been put in place to record all appointments for individuals. It will document details of annual health checks, and will include..... (full list provided).*
If required prescriptions should include a dosage interval and maximum dosage within 24 hours.	*There is frequent prescription audits carried out due to the Scottish Patient Safety Work currently. This includes ensuring the dosage intervals and maximum dosage is stipulated and a feedback process to allow improvement.*

Restrictions:

Service type	Number of recommendations	%
NHS Adult acute wards	8	46
Other services	10	54
All services	18	100

18 of the recommendations we made this year related to restrictions on the individuals that we met. Around 4% of all recommendations made and similar to last year's findings. This is perhaps a lower number than we might expect but many restrictions placed on individuals are categorised elsewhere. e.g. Mental Health Act.

The restrictions recorded under this category tended to relate to locked doors and physical restraint.

We recommended	**The service responded**
Managers should review the locked door policy and information provision of this to patients.	*X no longer has a locked door during daylight hours. The locked door which impacted the female units is now an open door. Entrance to the ward is now only through the external door at unit X which brings you into the building between units X and X.This door is open at all times throughout the day and is only locked for security purposes overnight. Presently it is closed at approximately 20:30hours which will change to a later time once the lighter nights arrive and the ward is opened from 09:00hours.*
Managers should ensure that assessment sheets and care plans in relation to the locked door policy are completed appropriately and this includes letting patients know how they can exit the ward should they wish to do so.	*Controlled Access and Egress care plans are within each individuals patients notes, monthly audit of documentation is carried out to ensure these are completed appropriately. Locked door policy is in place and signage is located at the entrance and exit of the main door.*
Managers should ensure that episodes of restraint are actively monitored and any significant episodes of restraint should trigger an assessment into whether the criteria for detention are met.	*This is discussed weekly at MDT ward round and reviewed out-with if required. Discussions about escalation in behaviour and the requirement for restraint are documented in the ward round documents.*

Other recommendations

We made 7 recommendations that we classified under Patient Safety, we did this where they related to an aspect of the Scottish Patient Safety Programme (mental health) and were not suitable to record elsewhere. Of the 7, all were within the NHS, 4 were in adult acute wards. These related to completion of incident forms and general health and safety issues.

The remaining 39 recommendations we made concerned training for staff, involvement of carers, risk assessment, including improvements required to menus and meals, staffing levels and social work involvement, access to interpreters delayed discharge paperwork ,transfer processes, finance and other miscellaneous recommendations not easily classified elsewhere.

Some examples of these.....

- *The service manager should liaise with local social work managers to agree workable arrangements for SW input into inpatient care*

- *Managers should rationalise the ward records and develop an electronic record able to store all information and make the process of accessing documentation easier for all*

- *Managers should review the catering arrangements and consider reinstating self catering budgets for patients who would benefit from this*

- *The level of delay in discharging patients in to the community is unacceptable and requires a clear plan of action to address the situation between Health and Council managers. The Commission require an action plan in relation to this issue.*

- *Processes should be reviewed to promote the opportunities for all families to benefit as much as possible from the Family Link Worker meetings and to ensure there is opportunity for families to feedback and tailor the meetings to meet their needs. Opportunities for families to contribute to the regular professional meetings regarding a young person should be reviewed.*

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.

Perhaps it is unsurprising that this remains the largest category given that care planning underpins the care treatment and support that everyone in hospital or a care home should receive. We believe that participation in care planning must be improved and we will liaise with Scottish Recovery Network amongst others to address this issue. We will continue to look closely at the care plans of those we visit and highlight areas of good practice.

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

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.

We will convey our concerns about unsafe prescribing of as required medication to Scottish Patient Safety Programme (mental health).

We will continue to review prescriptions to identify cases where informal patients are prescribed as required medication for agitation and report these to the RMO.

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.

We continue to report on the lack of dementia enabling design in hospitals and care homes, often quite simple and inexpensive changes can be made. We will continue to raise this as an area of concern in our meetings with Scottish Government,health Boards and the Care Inspectorate.

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 to improve this.
We will produce short guidance notes this year for care home staff and GPs on welfare Power of Attorney.

mentalwelfare
commission for scotland

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

Mental Welfare Commission (July15)