



Mental Welfare Commission for Scotland

Report on announced visit to:

Tippethill House, Rosebery Wing, Armadale, West Lothian EH48
3BQ

Date of visit: 16 January 2018

Where we visited

Rosebery wing is a 30-bedded NHS continuing care ward for women aged over 65 years with dementia and requiring complex care (often due to stressed and distressed behaviours). There are 22 single bedrooms with en-suite toilets and two four bed bays. We last visited this service on 27 March 2015.

On the day of the visit we wanted to follow up on the recommendations made at our last visit and these related to activities, life history information, Adults with Incapacity (Scotland) Act 2000 (AWI) legislation and environmental issues.

Who we met with

There were 27 patient on the day of our visit.

We met with four patients and reviewed the care and treatment of a further 10 patients and met with five relatives.

We spoke with the senior charge nurse (SCN), clinical nurse manager, nursing staff and student nurses.

Commission visitors

Susan Tait, Nursing Officer

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

Patients seemed comfortable in the ward and in the company of staff. Throughout our visit we saw staff interacting warmly with patients, responding quickly when they required assistance, and treating them with a respectful, caring manner. Staff were knowledgeable about people as individuals when we spoke to them.

A good culture was evident within the staff team, focussed on delivering person-centred care. Staff seemed positive and motivated. The relatives we spoke with said that they were very happy with the care, and in particular, the support and communication they received from nursing staff.

The files we looked at were organised and many had personal information in the 'getting to know me' document, but it was in the middle of the file. In order to have more immediate information about the person, it may be helpful to have it nearer the front. This was commented on in the last report.

The care plans we reviewed were variable in quality. Some were very thoughtful, person-centred and reflective of nursing interventions required to support individuals'

needs, in particular for stressed and distressed behaviour. Others were vague and did not give detailed information.

Recommendation 1:

Managers should arrange for an audit of all care plans to ensure that they reflect the care required.

We were told that only one and a half hours of consultant psychiatrist time is available every two weeks to review up to 30 patients, which only allowed for six monthly reviews, or occasionally three monthly reviews.

There is no pharmacy input for patients.

It is concerning that this patient group have restricted specialist psychiatric input for their care.

There is a general practitioner who visits Monday to Friday and physiotherapy, occupational and speech and language therapy are available on referral.

Recommendation 2:

Managers should review the medical and pharmacy input to ensure that the needs of the patients are met.

Use of mental health and incapacity legislation

All of the files we reviewed had certificates of incapacity (s47) under AWI in place as required. They were good examples of detailed specific treatment plans.

Where patients had a power of attorney or guardian, this was identified in the information sheet in the notes. For patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA), there was a sheet in the file which gave detailed information.

Rights and restrictions

Rosebery wing has a locked door for the protection of vulnerable adults and a locked door policy in place that requires all patients be risk assessed to determine whether they meet the criteria of requiring a locked door to ensure their safety.

Activity and occupation

There were two activities coordinators - one full time, weekly, and two full time on alternate weeks. Despite having a good level of activity staff and equipment, there was very little in the way of evidence to show what patients were actually involved in. This had been highlighted in the previous report and was a specific recommendation. We had been advised that this had been rectified. It was disappointing to see that this had

not been resolved. On the day we did see a small group activity initiated by nursing staff, as the activities coordinator was not available on the day of the visit.

Recommendation 3:

Managers should arrange for the review and update of all activity plans for patients.

Physical environment

The ward is dementia friendly, spacious and bright. There are interesting wall objects but there were no 'rummage boxes', which have been shown to help with distraction for distressed individuals. The SCN told us that they had been tried before but items had gone missing and there were no funds for replacement. However, there are now some funds which could be used for this and she agreed to trial it again.

There is a 'dementia café' with tea and coffee in the ward which gives a space for visitors to meet with relatives. Tippethill House is a private finance hospital managed by Care UK. It had been recently decorated. The main sitting area was a little stark though, the furniture was dated and did not look comfortable for older people. We were advised that they were awaiting delivery of new furniture for both sitting and bedroom areas.

There was signage on important areas, and all of the bedrooms had a memory box on the door where personal items could be placed to help with orientation for patients. Some of the toilets had been upgraded to provide contrast toilet seats but we were told that others would not be replaced until they were broken. We would suggest that this is discussed with Care UK and replacement toilets seats are purchased.

Some of the bedrooms had personalised items in them but we were told that nursing staff had been instructed by Healthcare Environment Inspectorate (HEI) to remove personal belonging such as photos, cards and other comfort items that relatives had brought in. This issues was raised by most of the relatives we met on the day. They said that it caused them some distress that they were not able to bring in items that were important to their relatives.

Recommendation 4:

Managers should liaise with HEI to determine why such restrictions have been put in place and make arrangements for patients to have personal belongings in their bedrooms as appropriate.

Any other comments

Of particular concern is that the ward still has eight beds in bay areas, which are only curtained and are situated on the main corridor. This affords little in the way of privacy and dignity. This leads to the issue that was raised in the last report, in 2015, that it was unusual to have 30 beds in a ward providing care for patients with such complex needs. We asked that a dementia environmental audit be carried out to include a

review of the bed bay areas and this has not happened. The SCN told us that she had visited other similar specialist wards to look at how care was delivered in different environments.

On the day of the visit staff told us of the difficulty they have in complying with monitoring they have been instructed to carry out; including food and fluid recording when there was no assessed need for the patient. There is also a tick box method of recording whether a patient has been offered food, fluid, taken to the toilet etc. This has replaced daily writing in a patient's notes as to how their day has gone, and removes the personalisation of information. This was also commented on by relatives who said that the ward seemed understaffed and nurses were stretched to provide the care they wanted to.

Recommendation 5:

As a matter of urgency, a review of the bed numbers, bay arrangement and staffing should be carried out. We will escalate this issue to senior managers.

Summary of recommendations

1. Managers should arrange for an audit of all care plans to ensure that they reflect the care required.
2. Managers should review the medical and pharmacy input to ensure that the complex needs of the patients are met.
3. Managers should arrange for the review and update of all activity plans for patients.
4. Managers should liaise with HEI to determine why such restrictions have been put in place and make arrangements for patients to have personal belongings in their bedrooms as appropriate.
5. As a matter of urgency, a review of the bed numbers, bay arrangement and staffing should be carried out. We will escalate this issue to senior managers.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Alison Thomson

Executive Director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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