mentalwelfare commission for scotland

VISIT AND MONITORING REPORT

Recommendations and outcomes from our local visits 2018

July 2019

Contents

Our mission and purpose

Our local visits

One way of achieving our mission and purpose is to meet with people in 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.

We are interested in the individual's experience of their care and treatment. Our findings and the recommendations we make will reflect on established good practice as appropriate (such as national health and social care standards, dementia standards for Scotland etc) but also include the observations we make on the day of the visit, the professional expertise and judgement of our visitors and, most importantly, what people we met with told us.

We share information with other key scrutiny bodies; e.g. the Care Inspectorate (CI), and Healthcare Improvement Scotland (HIS). We meet regularly with them through the Sharing Intelligence for Health & Care Group. This is a mechanism that enables seven national agencies to share, consider, and respond to intelligence about care systems across Scotland (in particular NHS boards) 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 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 also carry out national themed visits where we will visit individuals in similar services across the country then report on our findings.

How often we visit

The frequency of visits to people in a particular service is based on information from a variety of sources and can be increased or decreased depending on the intelligence we receive. Our focus on the visit will depend on the type of facility and the information we have. We aim for at least 25% of local visits to be unannounced and visit within NHS Scotland:

- Adult acute admission wards on an annual basis
- Child and adolescent mental health (CAMHS) in patient wards on an annual basis
- Other specialities e.g. perinatal inpatient, eating disorder units, every two years
- Dementia assessment wards on an annual basis
- Dementia continuing care wards every two years
- Learning disability (LD) assessment wards on an annual basis
- Learning disability (LD) continuing care wards every two years
- Adult rehabilitation wards every two years
- High secure wards (State Hospital) twice a year
- Medium secure hospitals on an annual basis
- Low secure hospitals, not less than every 18 months
- Prisons every two to three years.

We visit independent hospitals after discussion with HIS. We no longer routinely visit care homes on local visits but will do so if it is appropriate and after discussion with the CI.

Between 1 January 2018 and 31 December 2018 we carried out 107 local visits and we made 278 recommendations relating to these visits.

This is an increase from 2017 when we carried out 101 local visits.

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.

We expected an acceptable response to at least 90% of the recommendations we made. We were satisfied that services had responded appropriately to 97.5% of our recommendations.

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.

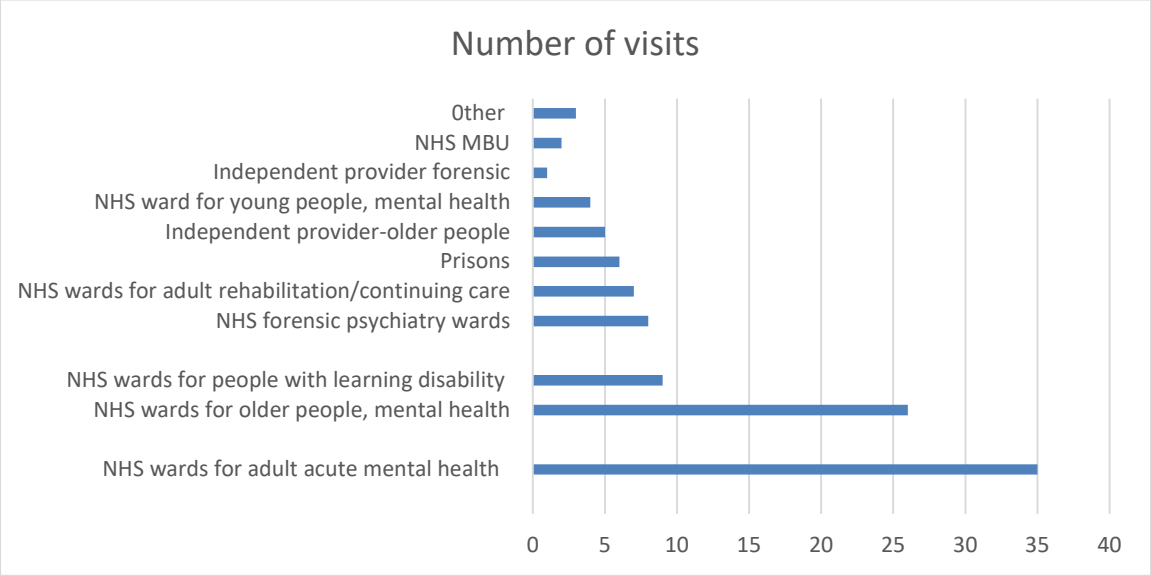
This report looks at where we were most likely to make recommendations and what they were about. We also give some examples of where improvements have been made and which may be of interest to other services across Scotland.

To make sure our recommendations are being acted on, we provide service managers with guidance about what they need to include in their response to us.

We then consider when the next visit is required dependant on the nature of the recommendation and the service's response.

Where we visited

Chart 1: Number of services visited
(1 January 2018 to 31 December 2018)



MBU: mother and baby unit
**Some visits will include visits to two or more wards.*

On 10 of the wards we visited, no recommendations were made (3 adult acute, 1 IPCU, 2 NHS rehab, I NHS medium secure forensic, 2 older people NHS and 1 LD NHS).

NHS wards for adult acute mental health were the largest grouping, representing 33% of visits, generating the majority of recommendations over the visit period.

Until 2017 we routinely visited care homes as part of our local visit programme but now only visit where we have discussed with the CI 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).

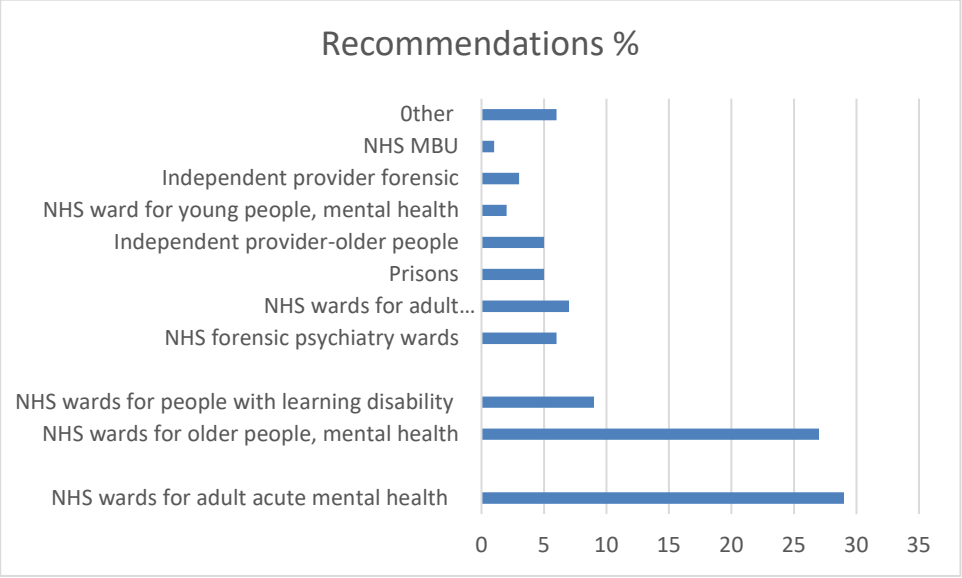
We recently reviewed our frequency and focus on visits to prisons and we aim to visit all prisons no less that every three years. We will be carrying out a national themed visit to prisons in the next two/three years.

Recommendation category

Table 2: Number of recommendations by category
(1 January 2018 – 31 December 2018)

Recommendation category	Total	%
Care planning, review and person centred care	78	28
Environment	39	14
MHA	32	12
Activities	30	11
AWI	23	8
Medication	16	6
Service issues	16	5
Access to Allied Health Professions	12	4
Rights and restrictions	12	4
Delayed discharge	8	3
Other	8	3
Carer	4	2
Total	**278**	**100**

Chart 2: Percentages of recommendations by type
(1 January 2018 – 31 December 2018)



The distribution of recommendation category across all recommendations is broadly similar to last year, with slightly fewer recommendations relating to provision of activity and more relating to the MH Act.

Care planning, review and person centred care:

Table 3: Number of care planning, review and person centred care recommendations by service type (1 January 2018 – 31 December 2018)

Type of service	Number of recommendations	%
Older People (NHS)	22	28
Adult Acute (NHS)	29	37
Learning Disability (NHS)	8	10
other	19	25
Totals	**78**	**100**

This area continues to generate the highest number of recommendations.

Twenty eight per cent of all the recommendations we made this year related to assessment, care planning, review and person centred care, slightly higher than last year when this figure was 27%.

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.

Recommendations in wards for older people 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 participation and a recovery focus.

On our visits we want to see that patients are involved and understand their care plan and we find that the quality and level of patient participation varies considerably.

We often recommended 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.

Last year we committed to publishing good practice guidance about person centred care plans, to help inform best practice in this area. We held a consultation event to establish a consensus view on best practice and will be publishing this guidance in early autumn 2019.The good practice guidance will focus on the essential components of a care plan, what is meant by person centred care and how to encourage and promote participation.

Some examples of our recommendations and responses:

We recommended	**The service responded**
Nursing staff should routinely discuss care plans with patients in one to one sessions and patient should be offered their own copy of their care plans.	Discussed at staff meetings and 1:1 supervision session with staff re: the importance of collaborative working with the patient .Now sharing copies of care plans with agreed person centred goals. Providing opportunities for patients to have ownership of goals and actions set. Incorporate all of the above into Effective Record Keeping Training delivered at hospital.
Managers should ensure that where a patient has particular communication needs these are addressed within a care plan to ensure there is consistency of approach and adequate input from an interpreter.	The SCN and Charge Nurses will ensure that where there is a patient who has a particular communication need that this is clearly documented within a care plan, giving clear detail around communication need also ensuring that the individual has adequate input from an interpreter to meet their communication needs.

Physical environment

Table 4: Number of recommendations by service type
(1 January 2018 – 31 December 2018)

Service type	Number of recommendations	%
Older People (NHS)	17	44
Adult Acute (NHS)	10	26
Forensic wards (NHS)	3	8
Other	9	22
Totals	**39**	**100**

This year 14% of the recommendations related to aspects of the physical environment where those we visited were living, a decrease on last year when it was 17%.Most of these recommendations related to ensuring the internal and garden areas of wards were adequately maintained.

During our local visits, we have also noted an inconsistent approach across the country in relation to the assessment and management of potential ligature points in inpatient areas.

We have advised in our local visit reports that managers should ensure that any corrective work to address potential ligature risks maintains the dignity and privacy of patients. We have met this year with Health Facilities Scotland (HFS), the Health and Safety Executive and the Scottish Patient Safety Programme- Mental Health, to address this issue and HFS have since set up a short life working group across all NHS Board areas to address these inconsistencies.

Mental health and incapacity legislation

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

Table 5: Number of recommendations by service type
(1 January 2017 – 31 December 2017)

Service type	Number of recommendations	%
Adult acute wards (NHS)	11	34
Older people (NHS)	7	22
Learning Disability (NHS)	2	6
Young people	2	6
Other*	10	32
Totals	**32**	**100**

12 per cent of our recommendations concerned the Mental Health (Care & Treatment) (Scotland) Act 2003 (The 2003 Act). This is an increase on 6% last year. Adult acute (NHS) wards accounted for 34% of all recommendations made in relation to the Mental Health Act.

The Commission has a duty to monitor the operation of the Act and one of the ways we do this is by visiting people subject to various provisions of the Act.
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.

Most of the recommendations in this category related to documentation and consent to treatment provisions of the Act.

The Commission has produced good practice guidance on these provisions and they can be found at https://www.mwcscot.org.uk/publications/good-practice-guides/

Adults with Incapacity (Scotland) Act 2000

Table 6: Number of recommendations by service type
(1 January 2018 – 31 December 2018)

Service type	Number of recommendations	%
Older people (NHS)	9	39
Adult acute wards (NHS)	2	9
Learning Disability (NHS)	4	17
Other*	8	35
Totals	**23**	**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.

Eight per cent of all our recommendations related to the 2000 Act; the majority to services for older people both in care homes and hospitals.

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 helpful 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[2] .These can be found at *www.mwcscot.org.uk*

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

[2] Common concerns with powers of attorney: November 2017 www.mwcscot.org.uk/media/233718/common_concerns_2017.pdf

Therapeutic Activity

Table 8: Number of recommendations by service type (1 January 2018 – 31 December 2018)

Service type	Number of recommendations	%
Adult acute wards (NHS)	7	23
Older people (NHS)	8	27
Learning Disability (NHS)	3	10
Forensic (NHS)	3	10
Other*	9	30
Totals	**30**	**100**

11% of the recommendations made this year concerned the provision of therapeutic activity, similar to last year's findings where the figure was 13%.

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 and can quickly lose their independence and skills.

Of these recommendations, approximately a third related to NHS adult acute wards, 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:

We recommended	The service responded
Managers should ensure that patients are informed of their rights in relation to specified person's restrictions.	Staff are reminded of their responsibilities around specified persons restrictions legislation. Staff will sign off in the record when a specified person has been informed of their rights. This will be added to the audit cycle of documentation.
Managers should take steps to introduce an activity programme and ensure that activities take place wherever possible on a daily basis.	Activities nurse successfully recruited. Works 12 hours dedicated time for activities on a one to one basis or in groups within the ward. Has attended training which will allow her to develop her role and to encourage other staff to engage with patients while she's not on duty.
Managers should ensure they monitor and record discharge planning activity for patients whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.	MDT to ensure that discharge planning activity is recorded on the MDT report and evidence discussion and actions. All senior MDT member to receive Beds Management Group minutes with details of additional information. Senior Management Team to liaise with HSCP colleagues regarding discharge planning activity for all individuals within service, including longer stay and delayed discharges

All our local visit reports can be found at www.mwcscot.org.uk

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