Mental Welfare Commission for Scotland

Report on announced visit to: Arran Ward, Dykebar Hospital, Grahamston Road, Paisley, PA2 7DE

Date of visit: 21 June 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have however been periods during the pandemic where we have been able to conduct our face-to-face visits. This local visit was able to be carried out face-to-face.

Arran Ward (formerly known as Arran and Bute Wards) in Dykebar Hospital is a 20-bedded inpatient mental health unit which functions as two separate services within the one ward. There are eight rehabilitation beds and 12 recovery beds. The rehabilitation part of the service is viewed as short to medium stay with an expected admission time of up to two years. All the patients in this part of the service have single rooms. The recovery part of the service is for longer stay patients with an expected length of stay of up to five years. The accommodation for this part of the service is provided in dormitories and single rooms. Previously the ward was two separate wards but this was converted to a single ward for the purposes of creating a combined rehabilitation and recovery model.

We last conducted a local visit to this service on 5 May 2015, but also visited in 2018 as part of our themed visit to rehabilitation wards in Scotland. Following our 2015 visit we made a recommendation to ensure patients' access physical health care commensurate with national screening programmes. We were keen to visit Arran Ward as it had been some time since our last local visit. We wanted to follow up on the previous recommendation and also find out how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and on the mental health of patients. We also wanted to to give patients an opportunity to raise any issues with us and to ensure the care, treatment and facilities are meeting patients' needs.

Who we met with

We met with six patients and reviewed the care and treatment of ten patients. No relatives requested to meet with us. We also spoke with the senior charge nurse, a charge nurse and other nursing staff on the day of the visit.

Commission visitors

Lesley Paterson, Nursing Officer

Mary Leroy, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

We noted that in terms of age range and physical health status, there is a very diverse group of patients in the ward. The current patient cohort are aged between 19 years and 71 years old and some are very physically compromised, with diagnoses of life limiting and terminal illnesses. Many patients have been in hospital for a considerable number of years and the chronic nature of their mental illness means their motivation to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. Nevertheless, we saw great efforts by staff to encourage involvement in both treatment and activities.

Care plans were person-centred, well-structured and detailed in terms of mental health, physical health and social care needs. They gave a clear account of the patient's journey and there was evidence of patient involvement and meaningful monthly evaluation. In some cases where patients had identified needs in relation to alcohol or illicit drug consumption, care plans lacked relevant detailed interventions. We provided feedback on the day of the visit regarding this. We were pleased to see that there are regular reviews of care and treatment plans recorded in both the multidisciplinary (MDT) paperwork and in the chronological notes. It was evident that the staff really know the patients and are invested in working closely with them to ensure the best outcomes. There was evidence that the MDT continued to consider any possible alternative placements, even for those patients who have been in hospital for long periods of time or for those who had experienced previous placements breaking down.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Chronological notes evidenced regular one-to-one discussions between the patient and nursing staff and it was clear that the patient's views on their care and treatment were sought and the patients were aware of their legal status. We could however, see little evidence of family involvement either in discussions regarding the patient's care and treatment or general contact with carers, and we were told there is no formal engagement process or carers group. Engagement with carers is fundamental to promote safety, support recovery and sustain wellbeing and ensures that the family have ongoing contact with the clinical team and are involved in their care in a meaningful way. We discussed this on the day of the visit and recommend managers ensure a process is introduced to meaningfully engage with relatives and carers to ensure not only their needs are met but that recovery outcomes are improved for patients.

The recent pandemic had an obvious impact on engagement with families and carers; however we heard about concerted efforts to ensure patients maintained contact with their

families, initially via telephones and iPads, and more recently visiting has been able to resume, in line with Scottish Government guidelines.

Many of the patients have physical health issues and mobility problems, some had substantial physical health needs, including others with life limiting illnesses. There are particular challenges in providing care for such a diverse group of patients and meeting their very different needs. Nursing staff told us they have access to additional training to meet the complex needs of their patient group. We were told that there is currently no visiting GP service provision to Arran Ward and all physical health care is provided by the Dykebar site Duty Doctor. Given the range of complex physical healthcare needs of some of the patients in the ward we were surprised to hear this and would suggest senior managers consider if this level of medical input is sufficient. We did however see evidence that all annual health checks are being carried out along with any other required monitoring including bloods for Clozapine therapy, lithium therapy, high dose antipsychotic monitoring and diabetic monitoring. This area was much improved since our last local visit to the ward.

Some of the patients on Arran Ward have DNACPR (do not attempt cardiopulmonary resuscitation) orders in place. The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

'Do not attempt CPR' forms were completed, however not all evidenced discussion with nearest relative or proxy as appropriate, nor had they all been reviewed within the requisite timeframe stated on the form. Additionally, not all staff on duty were completely aware of which patients were subject to the DNACPR policy.

It is fundamentally important that all relevant healthcare staff involved in the patient's care are aware that a decision not to give CPR has been made and documented on a DNACPR form. This not only ensures that CPR treatment in not erroneously withheld, but also that inappropriate, contraindicated and/or unwanted attempts at CPR which are of no benefit and may cause significant distress to patients and families is not attempted.

Overall feedback from the patients was positive. They described an atmosphere where staff were readily available, supportive and friendly. Patients reported that they felt listened to by staff. They reported no concerns about the care and treatment provision.

We saw evidence of good MDT input with two MDT meetings take place per week. Although we were told that all key members of the team attend each meeting, a list of attendees was not always evidenced within the notes, however the discussions, outcomes and actions were clearly recorded. Risk assessments were present, as were risk management plans and there was a clear link between risk, care, and treatment. There was some evidence of patient involvement, with some patients choosing to attend the meeting.

We heard that psychiatry and psychology provision is good with there being one part time consultant psychiatrist and two clinical psychologists. The ward has significant input from occupational therapy (OT) and referrals are made to dietetics, podiatry and speech and language therapy if required. Pharmacy staff attend the ward once per week and are also available for consultation as and when required.

We heard from patients and staff that advocacy input to the ward is easily accessible, responsive and the patients find it helpful.

Recommendation 1:

Managers should introduce processes to meaningfully engage with relatives and carers to ensure not only their needs are met but to improve recovery outcomes for patients.

Recommendation 2:

Managers should carry out an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

Therapeutic activity and occupation

Every file we reviewed contained comprehensive OT functional assessments where appropriate, reviews, a structured activity planner and a weekly activity programme. Patients had a copy of their activity plan at their bed area and all patients we spoke to reported they were happy with the range of activities on offer and there was plenty to do. They felt that activities offered to them are tailored to their preferences. There are a wide range of multidisciplinary-led activities taking place in the service including meal preparation and cooking groups, breakfast groups, art and crafts groups, quizzes, dominoes, bingo, walking groups, gardening, relaxation, music and film sessions. Prior to the Covid-19 pandemic there was a large focus on patient activity outings and sourcing appropriate external placements. We were told both these activities will resume as we emerge from the pandemic which we look forward to hearing more about on future visits.

Use of mental health and incapacity legislation

Fifteen of the twenty patients in Arran Ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Unfortunately, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were not all in place where required, meaning there were instances where psychotropic medication was being given without the legal authority to do so. We were told there were seven patients whose funds are managed by hospital managers under Part 4 of the Adults with Incapacity (Scotland) Act 2000; however it was not easy to find this information and associated spending plans within their clinical notes.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. It would seem from speaking with staff and patients on Arran Ward and also looking through the clinical notes that advanced statements are not promoted within the ward and staff were unclear on which patients have them and which do not.

The Mental Welfare Commission has produced advanced statement guidance which can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf

Recommendation 3:

Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form, where required, and a system of regularly auditing compliance with this should be put in place.

Recommendation 4:

Managers should ensure that the patient's file has a clear record of who has responsibility for the patient's finances and that all welfare or financial proxy details are clearly recorded.

Recommendation 5:

Managers should ensure that advance statements are promoted in the ward and these discussions are clearly documented in the patient's pathway and care plan.

The physical environment

As mentioned, Arran was previously two wards which have been combined as one; however the ward still feels like two distinct wards. The shorter stay rehabilitation part of the ward is bright, welcoming, has lots of colourful artwork on display and eight single bedrooms, whereas the longer stay recovery service was dull, much less welcoming, had little artwork on the walls, with four single rooms and two four-bedded dormitories. Each part of the ward felt like a completely different area.

Many wards across NHSGGC have been refurbished to provide patients with individual rooms and we would strongly encourage managers to consider the same here to ensure privacy and to protect dignity, especially given the fact that many of this particular group of patients in the recovery part of the service can be in hospital for fairly lengthy periods of time. This view was echoed by some of the patients we spoke with, with some of them being reluctant to have photographs or other personal effects on display for fear of another patient taking them. There was a small garden area to the rear of the rehabilitation part of the ward which was neat, tidy and well-maintained; however there was another larger garden area elsewhere in the unit which was dull, overgrown and untidy with lots of weeds. We were told that this smaller area is well used by patients and there is a gardening group who tend to it, however patients tend to use the larger garden only to smoke in. We would hope that any future refurbishments take consideration and include the garden areas too.

Recommendation 6:

Managers should ensure that the whole ward environment is welcoming and fit for purpose and refurbished to such a standard that the environment is unified to look less like two distinct wards.

Recommendation 7:

Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

Any other comments

Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment and finding new ways of working. We were impressed with the way in which the service has worked hard to be creative, flexible and adapt to best meet the needs of the patients. This view was echoed by both patients and staff we spoke with. We look forward in future visits to seeing how the positive changes that have benefitted some aspects of patient care have continued and developed in future models of care.

Summary of recommendations

1. Managers should introduce processes to meaningfully engage with relatives and carers to ensure not only their needs are met but to improve recovery outcomes for patients.

2. Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPR status of every patient on the ward.

3. Managers and medical staff should ensure that all psychotropic medication is legally and appropriately authorised on either a T2 or T3 form, where required, and a system of regularly auditing compliance with this should be put in place.

4. Managers should ensure that the patient's file has a clear record of who has responsibility for the patient's finances and that all welfare or financial proxy details are clearly recorded.

5. Managers should ensure that advance statements are promoted in the ward and these discussions are clearly documented in the patient's pathway and care plan.

6. Managers should ensure that the whole ward environment is welcoming and fit for purpose and refurbished to such a standard that the environment is unified to look less like two distinct wards.

7. Managers should plan to provide single room accommodation to ensure privacy and maximum benefit to patients.

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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