Mental Welfare Commission for Scotland

Report on an unannounced visit to:
Clackmannanshire Community Healthcare Centre, Ward 2, Hallpark Road, Sauchie, FK10 3JQ

Date of visit: 8 August 2024

Where we visited

Ward 2 is a specialist dementia unit located in Clackmannanshire Community Healthcare Centre. The unit is mixed-sex and provides assessment and treatment for older adults from the Stirling and Clackmannanshire areas. It has 20 beds and there were four vacant beds on the day of our visit.

There were initially six people who were considered as being 'delayed discharges', with this reducing to five by the end of our visit. Delayed discharge occurs when an individual is clinically ready, however, unable to leave hospital due to a lack of necessary care, support or accommodation available. One individual had been identified for long-term care and another person had recently been allocated a social worker. The remaining individuals were awaiting the completion of welfare guardianship applications.

We last visited this service in January 2023 on an announced visit and made recommendations in relation to record keeping, nursing care plans, family involvement and increasing the level of therapeutic activity for the individuals in the ward. Since then, we were informed that there has been ongoing scrutiny of Ward 2, due to a large-scale investigation (LSI) that commenced in May 2023. We heard that the team had worked well with services to address the concerns that had been highlighted. Work was required to complete comprehensive action plans that were intended to effect improvement in care delivery, and we were pleased to hear that the investigation had now concluded.

The returned action plan based on the Commission's recommendations made at the time of our last visit had not all been fully implemented by the time of this visit. We were aware of changes in key personnel, so this may have had an impact when in conjunction with the ongoing investigation. We were however disappointed that the recommendations we had set out, with the subsequent action plan from the service, had not been completed.

We had recommended that relatives and carers be included in the planning and review of care and treatment. Although we saw evidence of contact with relatives, by nursing staff, in order to capture their views and wishes prior to the multidisciplinary team (MDT) meetings, we would have expected to see more collaboration with families, especially given the number of them who held legal powers, and were proxy decision makers, in relation to their relative's care.

We had also made a recommendation about the record keeping system that the service had in place, and where the records had been transferred to the electronic system. We found this had not been completed and not all staff had accessed the relevant training. Written notes were still being completed, but we found some of these difficult to read.

Who we met with

We met with, and reviewed the care of six people, four of whom we met with in person. Due to the progression of illness, we were unable to have in-depth conversations with many individuals however, we observed them at various points throughout the day mainly when they were in the communal areas or when they were walking along the ward corridors. We were able to meet with one relative.

We spoke to staff on duty at the time of the visit, the interim senior charge nurse (SCN) and the clinical nurse manager (CNM).

We also met the consultant psychiatrist and chief nurse via video link later in the week to provide feedback and to have a further discussion with the wider team who were unable to attend on the day of our visit.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

What people told us and what we found

We observed one individual with their family celebrating their 80th birthday. They had sole access to a designated multipurpose room which was decorated as an informal community venue, including a simulated bar. The family acknowledged they could visit their relative at any time, out with protected mealtimes, which they found beneficial.

Although day to day care was described to us as “very good”, “wonderful” and there were “no complaints about the care”, they expressed some disquiet concerning accessing their relative’s responsible medical officer (RMO) and information sharing around potential future care environments. We heard of the relative’s anxiety about the future given difficulties they had experienced when two previous placements had failed. Nursing staff had made us aware of this issue prior to our visit and a meeting had been arranged.

The relative also advised us that they considered there to be insufficient staffing levels; this had led to the use of bank staff and a limited level of meaningful activity being offered. They did, however, speak of good links with and support from the Stirling Carers’ group and the outreach team which pre-dated their relative’s admission to the ward.

One individual we spoke with told us that they found the staff to be “really nice” and appreciated opportunities to get out for walks and coffee but would like to have access to the ward garden area. Another person told us they liked their room and the fact they were able to lock it but would like more opportunity to use the ward garden.

We also spoke with nursing staff and heard that the recent investigation had had an impact on staffing levels and morale. We heard that several experienced health care support workers (HCSW) had since left to pursue different career opportunities elsewhere in the health board. This had brought challenges with an increase in the use of bank staff and redeployment of staff from nearby Ward 1.

Daily partnership meetings were ongoing to manage any shortfalls, and we were told that the situation was beginning to improve, albeit slowly, with recruitment interviews being conducted after our visit had taken place. Monthly staff meetings had been introduced, in addition to a staff suggestion box. We were also told that since the investigation and a change in SCN, opportunities for training were promoted, however, staff felt unable to pursue these due to the staffing situation.

The staff group consisted of a mixture of registered nurses in adult care and mental health, as well as HCSWs. We were told there was a minimum of two registered nurses on each shift, always trying to ensure at least one of who was a registered mental nurse (RMN). The SCN and CNM were both registered adult nurses however, told us they had regular contact with SCNs at the mental health unit in Forth Valley

Royal Hospital (FVRH) for specialist support as and when required. A dedicated activity co-ordinator had been recruited recently.

Although the investigation had been demanding, it was felt that staff knowledge and confidence had increased, and there was more clarity about making referrals around adult support and protection (ASP) concerns. The ward continued to benefit from regular support from the ASP lead social worker. A multidisciplinary approach had been taken towards delivering training needs identified by the LSI, including input from the dietician. Additionally, training on stress and distress had been delivered by the psychiatric liaison service.

Care, treatment, support, and participation

Physical health was monitored comprehensively, with access to advanced nurse practitioners (ANPs) most days and a GP service on Thursdays and Fridays.

We found extensive assessments relating to physical health in the care planning booklet held in paper files. These were detailed, focussing on key areas such as hydration, skin care, nutrition, elimination, oral hygiene. The emphasis on this aspect of care and treatment was positive, given the significance of physical health in older people with a diagnosis of dementia, but there was no section in the document to care plan specifically for mental health needs, including the experience of stress and distress.

For some individuals we found care plans held on the electronic information system 'Care Partner' that appeared to have been written during a previous admission to the dementia unit at FVRH. These included stress and distress formulations and information about how to manage this. However, it had not been transferred to the handwritten files that were in daily use in the current ward, so it was unclear how regularly these were used as we learned that not all nursing staff accessed this information system.

The ward had a named nurse system in place, and we found detailed 'getting to know me' documentation that provided invaluable information about the person's history, including their likes and dislikes. We also noted regular involvement from ANPs where needed. Nicotine replacement therapy was offered to individuals who required this due to the ward's adherence to the NHS national smoke free legislation.

Evidence of regular participation in meetings and care planning was limited however, we did find an example where an individual's views were recorded in the minute of an Adults with Incapacity (Scotland) Act, 2000 (AWI Act) meeting, and they had been supported by independent advocacy in doing so.

We also saw recording of family contact with nursing staff, however, it was unclear when the RMO reviewed individuals or their involvement with relatives, as there was

no record of this in the continuation notes, nor in the multidisciplinary team (MDT) meeting record. The relative we met had raised this with us and given they were also the legal welfare guardian for this individual, we highlighted this concern with the SCN during the visit and again to senior managers at the subsequent online feedback meeting. We are therefore repeating our recommendation from our last visit.

Recommendation 1:
Managers should ensure that where appropriate, relatives/carers are included in the planning and review of their relative's care and treatment.

Care records
On our previous visit a recommendation was made that a review be undertaken to ensure all information was current, up-to-date and held in one place. The action plan we received from the service documented that a decision had been reached for the continuous care records, care plans and MDT records to be transferred to the electronic recording system 'Care Partner'. We were disappointed to see that only MDT meeting records were now held on Care Partner, with other documentation continuing to be written in the paper files.

We found that the multiple systems in place were confusing, and we considered this to be a risk as important information was not accessible to all, potentially increasing the risk that individuals care needs may not be fully met.

Recommendation 2:
Managers should ensure a further review of the record keeping system is undertaken to ensure all information is current, up to date and held in one place.

Training modules were available on the NHS Education for Scotland (NES) Turas e-learning platform, but we were told that not all staff had completed this training.

On reviewing the written file notes, we found some entries difficult to read due to some of the handwriting being illegible, which was not in accordance with Nursing and Midwifery Council (NMC) record keeping standards. We also saw gaps between entries which should have been closed off to prevent other entries being inserted.

Recommendation 3:
Managers should ensure that nursing documentation complies with the Nursing and Midwifery Council record keeping standards with continuous care records providing a legible detailed holistic account of a person's physical and mental wellbeing.

Daily recording sheets completed by nursing staff were held in the paper files and gave an overview of the person's day, including personal care, dietary intake, sleep and medication. Some of the records noted "evident around the ward" and "had an active day" which provided limited information of the individual, making it difficult to

get a clear understanding of what this meant in relation to an individual's mood, their clinical presentation, how they occupied their time or how staff encouraged independence, choice and whether psychological needs were being addressed.

We noted one entry referred to an individual "pacing around the ward" and that emergency medication had been given, but there was nothing specifically recorded as to how the stress and distressed behaviours were managed prior to this, or what effect the medication had for the individual; it was unclear whether the extent or impact of any nursing interventions had had in applying non-pharmacological interventions prior to the use of medication as a last resort.

From the sample of records we reviewed, we were unable to locate entries detailing one-to-one interactions with staff on duty or with an individual's key worker. We found the availability of risk assessment documentation variable. One risk assessment document on Care Partner had been closed, so it was unclear whether this had been in place when the person had been in a previous ward; this had not updated following transfer to Ward 2.

Do not attempt cardiopulmonary resuscitation (DNACPR) forms, recommended summary plan for emergency care and treatment (RESPECT) forms and 'getting to know me' booklets were all completed and available in the paper files.

There was a separate section to record family contact, where we were found evidence of regular contact between relatives and nursing staff, and sharing of information following MDT meetings. This also documented relatives' views and wishes.

Throughout the day we saw designated staff completing daily 'care and comfort' notes on a handheld mini digital electronic device. This system was called E-care, and we were told information was collected on pain, skin care, presentation status, dietary intake, toileting needs and presentation during interactions. This was completed two hourly and automatically uploaded to a database but not linked to Care Partner. We felt this was a missed opportunity, as pertinent care records were being stored in a third location and was used for statistical purposes.

Although the care planning booklet was good, it focussed primarily on physical health care needs. An entry regarding the risk of an individual becoming physically aggressive when staff delivered personal care was recorded in the booklet in the section "wandering around the ward". Despite this being highlighted, there was no specific or detailed information that was used to inform any interventions which may have been helpful to understand and reduce the individual's associated distress.

We found mental health care plans for stress and distressed behaviour for some people on Care Partner however, they appeared to have been written during a previous admission and not everyone had one. We found an example that included a

stress/distress formulation that provided detailed information about managing this, however, it did not appear to have been used in the current ward.

For others we noted that copies of mental health care plans from a previous ward admission had been printed off and included in the files; we did not find these to be person-centred to individual needs and they lacked regular review. As not all nursing staff used Care Partner, it seemed improbable they had access to this key information. The lack of mental health care planning did not provide staff the opportunity to fully exploring interventions that could provide helpful information and a 'what works/what doesn't work' approach. We were told that the ward lacked regular psychology provision and given that it is a specialist dementia unit, there should be a more prominent focus on managing stress and distress.

Recommendation 4:
Managers should ensure all nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, and identify clear interventions and goals.

Recommendation 5:
Managers should ensure that all nursing staff include summative evaluations of care plans in the notes that clearly indicate the effectiveness of interventions being carried out and any required changes to meet care goals.

Recommendation 6:
Managers should ensure regular auditing of care plans to ensure consistency in recording and review to achieve parity between physical and mental health care needs.

The Commission has published a good practice guide on care plans[1]. 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.

We did find that the whiteboard in the duty room was informative and up to date. It was well presented, provided clear information on whether individuals were subject to formal legislation, their time off the ward status, whether a treatment plan was in place for physical health care, if the person was deemed to lack capacity for this decision, observation status, alert status, external professional involvement including the professional's details, admission details, who the named nurse was. This facilitated the sharing of comprehensive information at a glance.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Multidisciplinary team (MDT)
MDT meetings took place weekly with every individual on the ward being reviewed on alternate weeks. The MDT consisted of psychiatry and nursing staff, with social work and pharmacy attending where required.

Discussion included outcomes and further actions which were recorded on Care Partner. The template on Care Partner provided a good structure. The notes gave informative updates including details of who attended, however, family participation/involvement in the care and treatment was difficult to find in these reviews.

We noted examples of recorded updates from social work where staff sought advice, although for one individual we noted that there had been a late referral for social work involvement despite the MDT previously concluding the individual was suitable for long term care. We felt that this process could have been commenced at an earlier opportunity, and even prior to the individual's transfer to Ward 2.

There was evidence of the RMO's discussion with the mental health officer (MHO) in relation to the necessity for legislative powers of detention. We also found a separate MDT record held in the nursing notes, but it was unclear whether this was a nursing update for the formal meeting, causing confusion due to different methods used for capturing information.

Use of mental health and incapacity legislation

On the day of the visit, seven people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Documentation relating to the Mental Health Act was accessible in the files and in order.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. On one T3 certificate we found that one regular and one as required medication had been prescribed but not authorised on the T3 certificate. We highlighted to the SCN who agreed to see this was rectified.

Where individuals received medication covertly, we found evidence of a care pathway template being used. We found one where the section referring to whether this was least restrictive option had not been completed, nor had the method of administration been recorded. Feedback was provided to the SCN in relation to this.

Where an individual lacks capacity to make decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that the treatment

complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found copies of s47 certificates with corresponding treatment plans but noted one had not been signed by the family member who had been named on the form. This s47 certificate had a capacity assessment attached however, every box had been ticked which did not appear to be decision specific.

We found copies of power of attorney and welfare guardianship certificates in the files but some of the written notes referred to someone being 'AWI' and did not distinguish what this meant for the individual. This contrasted with the clarity of information had been recorded on the whiteboard.

Rights and restrictions

Ward 2 operated a locked door policy commensurate with the level of risk identified with those receiving care and treatment, and information was displayed providing a clear explanation regarding this.

From our review of the records, we noted that individuals had access to the local Forth Valley independent advocacy service and a curator ad litem with regard to safeguards and the Mental Health Act appeals process. One individual had recently been supported by advocacy for the purpose of gathering their views prior to an AWI Act case conference and had voiced clear wishes about wanting to go home. The individual who had been admitted to hospital on an informal basis expressed these views during our visit. Although the person appeared settled on the ward and was not attempting to leave, we felt that this should be reviewed regularly in view of their rights, given that they were in a locked environment.

We saw their time off the ward (TOW) being restricted with no specific risk assessment in place and found a copy of a leave planner in place for TOW but the last recorded date on the document was in April. We were able to see that this was reviewed recently according to the MDT meeting record on Care Partner. Given that this was recorded differently, this was confusing and unclear.

Recommendation 7:
Managers should ensure individuals are given information about any restrictions they may be subject to, that they are made aware of their rights around these and are reminded of these rights at appropriate intervals.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We were pleased to learn of the recent appointment of a full-time activity therapist. This was a new role for the team however, nursing staff had already noted benefits from this development.

Generally, activities were programmed from Monday to Friday, but we were told there would be some flexibility to cover specific events that may be organised at weekends. Otherwise, nursing staff remained responsible for providing therapeutic activity when the activity therapist was not on duty.

Activities should be person-centred, reflecting the interests of individuals and provided as part of managing individuals' stress and distress, to reduce the use of medication to manage these symptoms. We found copies of individual interest checklists with corresponding care plans available in the designated activity room. Records included activities, such as attendance at local community venues.

The programme was still being established so we found limited availability of activity, however, were told this would be developed further in the coming weeks. We saw photographs from a recent garden party event where individuals and family had participated. Individuals enjoyed weekly visits from therapet and the Elderflowers programme, an organisation who aimed to provide meaningful connections for people affected by dementia, positively contributing to their well-being and quality of life.

The physical environment

The layout of the ward consisted of individual bedrooms with en-suite facilities. The rooms were clean, personalised, spacious and the décor was fresh, bright and appeared generally well maintained.

Bedrooms were personalised with picture boards on walls with information about individuals' likes/dislikes and where relatives and staff could record important information about the individual. Each bedroom had a lock which individuals could lock from the inside if assessed as capable of using this. Nursing staff were able to gain access to bedrooms where required using a master key. Additionally, bedrooms had door sensors with activation alarms that would be triggered if individuals left their rooms. Staff could control these at specific intervals during the day. We were unable to find any risk assessments, policies or guidance around the use or monitoring of this technology.

Communal areas included a dining room, lounge area and a separate activity room which had recently been decorated with a large and colourful mural to attract interest and brighten the room. There was also a multipurpose room which could be

used for activities and great effort had been made to decorate this room in the style of a community venue. The ward benefitted from beautiful, well-maintained gardens, but the door was kept locked so people could not freely access this. We heard from relatives and staff that the ward could be very warm due to lack of ventilation from the doors being closed. We would suggest that given the feedback from those that we spoke with about the importance of being able to access the garden area, a solution be identified to creating access to this area for individuals in the ward and for their families/carers. We look forward to seeing how access to the gardens develops.

Summary of recommendations

Recommendation 1:
Managers should ensure that where appropriate, relatives/carers are included in the planning and review of their relative's care and treatment.

Recommendation 2:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

Claire Lamza
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 Commission 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 an individual's care, treatment, and support are 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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