Mental Welfare Commission for Scotland

Report on announced visit to:
Ward 24, University Hospital Monklands, Monkscourt Avenue,
Airdrie, ML6 0JS

Date of visit: 17 February 2025

Where we visited

Ward 24 is a 20-bedded, mixed-sex, acute admission unit caring for individuals with a diagnosis of dementia, who are often at an advanced stage of their illness and who are experiencing extreme stress and distress behaviours. On the day of our visit, there were 12 people on the ward.

We last visited this service in September 2022 on an announced visit and made recommendations about the environment, on care planning and involving proxy decision makers.

On the day of this visit, we wanted to follow up on the previous recommendations and look specifically at activity provision and communication with relatives.

Who we met with

We met with and reviewed the care of five people. We spoke with one relative.

We spoke with the service manager, the senior charge nurse, the lead nurse and the consultant psychiatrist.

Commission visitors

Mary Hattie, nursing officer

Anne Craig, social work officer

Audrey Graham, social work officer

What people told us and what we found

Throughout our visit we saw professional, compassionate interactions between staff and the people they were caring for. We found the staff team to be sensitive to the needs of those in their care and staff responded with warmth and kindness. Those who were able to speak to us told us that staff "looked after me great" and "they are always kind".

We heard from relatives that communication was "first class", "staff update us every time we come to the ward" and "the consultant meets with us monthly to go through things". We heard "from the nursing assistants to the senior charge nurse, they are all excellent".

We heard from the nursing team that the absence of a dedicated activity co-ordinator was a big gap in the team and while staff did their best to provide activities on an ad hoc basis, they were unable to provide a structured programme or gain benefit from the external resources that an activity co-ordinator could tap into.

We were told that there was a short life working group that was developing a training plan for older adult inpatient services which would ensure staff working in this area reached the skilled level of competence in the promoting excellence framework. This would include issues of frailty as well as stress and distress.

Care, treatment, support, and participation

Records were held in two formats. The risk assessments, care plans, multidisciplinary team (MDT) reviews and chronological notes were held on the electronic record system MORSE; paperwork for the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), Adults with Incapacity (Scotland) Act, 2000 paperwork (the AWI Act), Getting to Know Me (GTKM), anticipatory care plans, and Do Not Attempt CPR (DNACPR) paperwork were all held in a paper folder.

We found completed GTKM documentation in all the files we reviewed, however the level of detail recorded in these varied considerably. GTKM is a document which collates information on an individual's needs, likes and dislikes, personal preferences, and background and enables staff to understand what is important to an individual and how best to provide person-centred care while they are in hospital.

Recommendation 1:

Managers should regularly audit the Getting to Know Me documentation to ensure this is fully completed and life history information is recorded and follows the individual when they move to a further care placement.

During our previous visit, we found life history information was being progressed. On this visit, we discussed the importance of this work and the need to ensure that this was completed as fully as possible for each individual, so that the information could accompany them when they left hospital. It was disappointing to find that on this occasion, this information was missing in the files we reviewed.

We found detailed risk assessments that had been regularly updated. Care plans varied in the level of detail and person-centred information they contained. While we found care plan evaluations had been regularly completed, some care plans had not been updated to reflect the changes in the individual’s presentation or their needs that were noted in these.

Recommendation 2:
Managers should review their audit processes to improve the quality of care plans to ensure these are consistently person-centred and updated to accurately reflect the individual’s current needs and planned interventions.

We reviewed several patients who experienced considerable stress and distress and had been prescribed as required medication to assist in managing, or where they required additional one-to-one support for this. In this type of situation, we would have expected to find a detailed care plan for managing stress and distress, setting out potential triggers for this and suggesting different strategies to distract the individual and to help alleviate their distress. This is often formulated using the Newcastle model, a framework and process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

Recommendation 3:
Managers should ensure that there is a clear person-centred plan of care for individuals who experience stress and distress. This should include information on each individual’s triggers and strategies, which are known to be effective for distraction and de-escalation.

Several of the people whose care we reviewed had significant physical co-morbidities. These were reflected in care plans, were being well managed and the needs arising from these addressed.

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.

Multidisciplinary team (MDT)

The ward is covered by five consultants, who each have a geographical community patch. Having to attend up to five MDT meetings each week does take up a significant amount of nursing time. We were told that there is a plan to move to a

---

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

different model where there will be one consultant for the ward; this will reduce the amount of nursing time spent in meetings and increase the amount of consultant time available on the ward.

The ward also has input from the advanced nurse practitioner, a pharmacist and has a link social worker who attends the ward once a week. On our previous visit, there was dedicated input from psychology and occupational therapy staff, however we are advised that due to staffing difficulties, occupational therapy, and psychology are now only available on a referral basis.

The MDT notes recorded who was present and decisions that were made. Relatives were invited and attend many of the meetings. Consultation and involvement of relatives in decisions was clearly recorded. Where relatives did not attend meetings, they were provided with regular updates by nursing or medical staff, either by phone or when visiting the ward.

Use of mental health and incapacity legislation

On the day of the visit, seven people were detained under the Mental Health Act.

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. We found the certificates authorising treatment (T3s) under the Mental Health Act were in place where required, although one individual was prescribed a medication which was not authorised on the T3 certificate. This was addressed during our visit by the advanced nurse practitioner who attended the ward.

Recommendation 4:
Medical staff should ensure that where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

In relation to the AWI Act, where individuals had granted a power of attorney (PoA) or was subject to guardianship order, copies of the powers were available in all the files we reviewed. There was evidence throughout the chronological notes and MDT minutes of consultation with proxy decision makers in relation to care and treatment.

Where an individual lacks capacity in relation to 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 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 s47 certificates in place for adults who required this, and proxy decision makers had been appropriately consulted.

For patients who were receiving covert medication, covert medication pathways were in place.

Rights and restrictions

Ward 24 continues to operate a locked door, commensurate with the level of risk identified for this patient group. There was a policy in place and individuals and their relatives were informed of the need for the locked door on admission. It was good to see information at the entrance to the ward for all to view.

The ward operated open visiting and encouraged relatives to visit at mealtimes, should they wish to support their relative during this time.

The ward was looking to further develop carer involvement and as part of this several staff were undertaking “carer aware” training. The senior charge nurse was also working with the practice development nurse to improve the information available to relatives coming into the ward. We look forward to seeing the outcome of this on our next visit.

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.

Activity and occupation

We found little evidence of activity provision in the care notes we reviewed, and there is no structured activity programme on offer in the ward.

We heard that nurses provided activities on an ad hoc basis, however we heard that it was difficult for the nursing team to plan and carry out activities on a regular basis due to the high levels of clinical activity and fluctuating demands on their time. We were told that consideration was being given to creating an activity co-ordinator post and there was a bid in for funding the creation of this post.

Activity provision plays an important role for individuals with dementia; it is an essential component of a therapeutic programme. Having a dedicated co-ordinator would enable the development of a structured activity programme and allow for the development of links to outside services such as music in hospitals, therapet services, football memories, singing for the brain groups, links to other Alzheimer’s Scotland resources and to local libraries and museums which can often provide reminiscence resources. All of this would positively contribute to the individuals’ experiences on the ward.

---

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

Recommendation 5:
Managers should progress the provision of an activities co-ordinator post to ensure that activity provision is prioritised, so individuals have access to a range of therapeutic and social activities on a daily basis, to meet their needs and preferences.

The physical environment

The ward is situated on the lower level of a large district general hospital. The ward has five single rooms and five three-bedded dormitories.

The communal areas of the ward consisted of two lounges, a small sitting room/activity space, a dining room, and an enclosed garden that had several brightly coloured seating areas. The ward was bright and clean and had space for people to sit and rest in the corridor, as well as in the communal rooms.

Signage was dementia friendly, however the ward was very clinical and bland; it would benefit from the introduction of artwork to provide colour and interest to the environment.

The second sitting area was out of use when we visited and the TV had been broken and removed and the lights were flickering badly making it unpleasant space to be in. We were told that this had recently been reported to maintenance and would be attended to soon.

Recommendation 6:
Consideration should be given to funding improvements to the décor in the ward to make it more welcoming and homely.

We saw one of the areas used for visitors and were told how this space is adaptable for the use of family members, where needed, to remain with a terminally ill patient which provides a small space for them at a difficult time in their lives.

Summary of recommendations

Recommendation 1:
Managers should regularly audit the Getting to Know Me documentation to ensure this is fully completed and life history information is recorded and follows the individual when they move to a further care placement.

Recommendation 2:
Managers should review their audit processes to improve the quality of care plans to ensure these are consistently person-centred and updated to accurately reflect the individual's current needs and planned interventions.

Recommendation 3:
Managers should ensure that there is a clear person-centred plan of care for individuals who experience stress and distress. This should include information on each individual's triggers and strategies, which are known to be effective for distraction and de-escalation

Recommendation 4:
Medical staff should ensure that, where a T3 certificate is required, all medication prescribed is appropriately authorised on this.

Recommendation 5:
Managers should progress as a priority the provision of a dedicated activities co-ordinator to ensure that activity provision is prioritised, so individuals have access to a range of therapeutic and social activities on a daily basis, to meet their needs and preferences.

Recommendation 6:
Consideration should be given to funding improvements to the décor in the ward to make it more welcoming and homely.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk