Submission for Mental Capacity Action Day

1. ***Title of project:***

A Life More Ordinary

2. ***Principal authors/ owner/ contact point:***

Margi Daw Merseyside CCGs margi.daw@haltonccg.nhs.uk Tel: 0151 495 5055

Jackie Goodall Cheshire CCGs jacqueline.goodall@nhs.net Tel: 07774331646

3. ***Pre audit perception of authors***

By embedding the MCA into every day clinical practice and care this would reduce the numbers of people deprived of their liberty and reduce restrictive care.

Deprivation of liberty is poorly understood by a large number of healthcare workers. Care planning does not include reference to restrictions on care or conditions of DoLS

There is a belief that staff are too busy to provide some social interaction. In an acute setting this could be something as simple as a hand or foot massage to aid the person to sleep and a carers time is the only cost incurred. Restricted visiting times still prevent families from supporting care and interaction. Not enough time is dedicated to the importance of interaction and the potential impact on well-being.
A variance in the role of the volunteer

4. ***Project detail (outcome of visit(s))***

Community setting

The hospital is set in its own grounds and has 30 beds for intermediate and rehabilitation beds. There is a high ratio of single side rooms (18 in total). All of the beds are on the ground floor and there is a calm, open and airy feel on the unit. There's seating area outside of the bays identified for those people who like to walk around and sit outside of their room or bay. The number of DoLS is minimal and the Matron of the unit is keen to upskill and build on existing knowledge in the field of MCA and DoLS. A resource folder for staff to refer to is available and was up to date

We noted a varying degree of knowledge and it was identified that this information was on a need to know basis depending on grade and skills. Training includes level 2 safeguarding and includes MCA, DoLS and the role of the IMCA.

There are activities planned each afternoon but no activity coordinator in the staffing establishment. The activities are led by the nursing team and there was evidence of weekly up to date activities.
"Patient passports" or "This is me" information wasn't available for those who lacked capacity and who may need support with communication although some discharged patients families have shared them. This was identified in the matron's action plan going forwards.
Patient's capacity was discussed at MDT meetings
There were no volunteers currently working on the unit and no access to a garden space despite being on the ground floor
There is a positive culture of every person receiving person centred care allowing patients to get up at their preferred time

There is some flexibility with visiting hours and especially if the patient is anxious and would benefit from this, however it is not generally encouraged in the morning when ward activity is high. It would appear that good relationships were forged with families.

The ward manager stated that they had no access to specialist seating however it was unlikely that they would be caring for someone who required this.

Nursing Homes

In one home there were 46 out of 57 authorised DoLS and the completion of these was the responsibility of the Manager and deputy manager, however both recognise that the registered nursing staff would benefit from some exposure and completion of application forms

They are using a dementia wellbeing tool and Cornell depression scale as well as being proactive with the Namaste pilot to provide residents with a calm and sensory environment to reduce agitation and promote wellbeing. Staff enjoyed this area of work and feel that it's highly beneficial to those residents who are often very distressed

A new activity coordinator started on the day of our visit and already in place are a

- Potting shed / man shed
- Garden off the lounge,
- Several smaller lounges
- Empathy dolls
- Activities available around the home for residents to pick up when they wanted to
- Regular events (day and evening) including themed parties, with families and friends being encouraged to attend
- Boxes with memories and toys and paints on the table

During our visit residents were not encouraged to sit down and positively encouraged to wander and staff were seen to display appropriate affection to the residents and it was well received with no objection.

Reminiscing passport – "my memories" this is very detailed, activity coordinator tasked to get them completed.

When considering the MCA and supporting residents with decision making the menus were displayed as a plated up meal and a resident was able to view the plates before choosing their meal. Staff reported that they gave residents a choice of clothes to wear in the morning rather than staff making the decisions

However despite the activities available we saw one resident sat for 2 hours with no interaction and no offer of being taken to the toilet

It was noted within the second home that there was a clear line of responsibility for the MCA and DoLS and also that senior staff or dedicated staff undertook the MCA's and DoLS applications. There was an RMN taking the lead for training and the coordination of DoLS and the manager informed us that she had done a lot of training in relation to MCA and DoLS**.** At the time of the visit there were 27 DoLS in place. The manager reported that there were a number of the DoLS either not being authorised or else having an extended gap in the home receiving the authorisation paperwork.

There was evidence of the least restrictive care being given however the environment was not entirely suitable for those living with dementia or cognitive impairment. The lounge and dining room was very open and noisy due to general noise, alarms constantly buzzing and the lack of soft furnishing. As visitors it felt very stressful to ourselves and would likely increase the anxiety of the residents living within the home and being constantly subjected to this kind of environment

We saw evidence of special days and events with photographs on display on the wall of the home. These were also a talking point for residence to reminisce. There is a garden that can be accessed by service users.

Acute providers

The overall theme for the acute trusts was the disparity in understanding a DoLS and the limited assessment of the mental capacity assessment. This was usually left to the senior nursing team's medical staff and advanced practitioners. However there was evidence of good practice whereby the responsibility of applying for a DoLS was coordinated by a band 3, discharge coordinator. On some wards it was the responsibility of the named nurse (band 5) to complete an application form but this didn't appear to be normal practice on every ward.

The knowledge was variable but no negative concerns were raised. There were few patients objecting and we did not observe any patients on a 1:1. The staff relayed that if concerned about someone they would generally consider someone staying in the bay at all times (either a registered or unregistered member of staff)

The Trusts both reported that authorised DoLS rarely came back with any conditions unless related to discharge and the number of DoLS not authorised during the patients stay was high with the both hospitals asking for an extension to the urgent application. Local Authority DoLS teams have explained that they were no longer prioritising applications where the care was least restrictive and the patient or representative were not objecting to their placement in hospital. There was minimal evidence of reminiscence / activity boxes. All staff at one Trust were complimentary of the support of their dementia lead. The few activity resources that were viewed were in the form of games, cards and books but staff reported they were rarely used, this was said to be mainly due to other priorities and time constraints

There were a number of DoLS not authorised however the LA DoLS teams are not always routinely informed if there is a change in the person's capacity.

Staff training for MCA and DoLS was delivered as an e-learning package and most managers stated that they preferred the face to face training delivered by the safeguarding team as it was often scenario based and could be related to clinical practice. There was a lack of understanding when staff were asked what the DoLS process was and the majority of junior staff questioned (HCA's and band 5 nurses) were unable to explain the MCA and the reason for applying for a DoLS. In the more acute wards qualified staff were unable to spare any time to talk to us and our conversations were mostly had with the ward managers

Dr's, an OT or an ANP were found to frequently complete the mental capacity assessments as nursing staff didn't feel competent to complete them

There was written evidence of completed mental capacity assessments and best interest meetings being held.

With the exception of one of the rehabilitation wards, staff did not feel that engaging those patients lacking mental capacity who were being deprived of their liberty in meaningful activities was an important part of patients care. However this was mainly due to staffing resources.

The rehabilitation / intermediate care ward was large and had a calm and quiet environment conducive to those transferring to a home or care home setting. Although activities were encouraged and supported by the OT there was no access to a garden or fresh air despite the purpose built ward and ground floor facilities.

On one acute ward the Ward clerk was happy to have patients sat with her to engage in conversation and the majority of wards had access to volunteers. However there was a definite disparity in the role of volunteers with some being used to give out drinks and others to actively engage in conversation and activities.

4a. possible outcomes of inactivity and lack of stimulation

- Increased anxiety/depression resulting in complex medication regime. This can result in lethargy and additional side effects for the resident.
- A DoLS may be required
- More prone to physical deterioration and inactivity. This can increase the risk of pressure ulcers, falls, injuries and contractures of the limbs.
- Person can become bedbound making chest infections and hospital admissions more likely. Many residents will deteriorate further or fail to recover.
- Contractures - bedbound

4b. Consideration

It is more likely that the increased cost of care, support, hospital treatment and medication will be higher compared to the cost of providing quality interaction and stimulation to patients/residents. This is likely improve the persons mood and could also lead to slower physical and mental deterioration

5. Conclusion in brief

There was generally poor understanding of the MCA and the effects of depriving patients of their liberty within acute settings.

Care homes are trying to improve quality of life and provide the least restrictive care however this is dependent on the money made available from the provider and the employment of an activities coordinator.

An acute setting is not conducive to providing person centred care to someone living with dementia. There is a lack of understanding as to how important this is to recovery and reducing distress and agitation. The wards are busy and chaotic which adds to confusion and subsequent agitation. The privacy and dignity of such patients is compromised with long periods of time in bed with reduced interaction. The culture is generally one of when a person is ill in hospital their care is dictated by the environment, facilities and staffing available rather than their needs as a person.

There is evidence of the role of activity workers making a difference to residents within care homes however they are generally a very small resource, usually of one person; this can sometimes be a part time staff member to work across a number of units. This situation can be difficult for residents with dementia as there will likely be lack of recognition for the new workers and no continuity in activities.

There is little evidence within both Nursing home and Hospital settings in relation to people having access to their individual interests. People who do not "make a fuss" are observed to be less likely to have interaction from staff.

Many people in hospital wards have their own rooms; this can be isolating and lacking stimulation. Nursing staff don't have the capacity to provide activities or to people out of the busy, noisy environment.

There was limited evidence of mental capacity assessments or best interest decisions noted within patient files.

Many patients in acute services are either fit to leave but are awaiting discharge to appropriate care facilities or may require the fitting of equipment prior to discharge. They will continue to remain in the hospital without having the same freedom and opportunities as those who have capacity.

If people have the mental capacity to make decisions would they choose to -

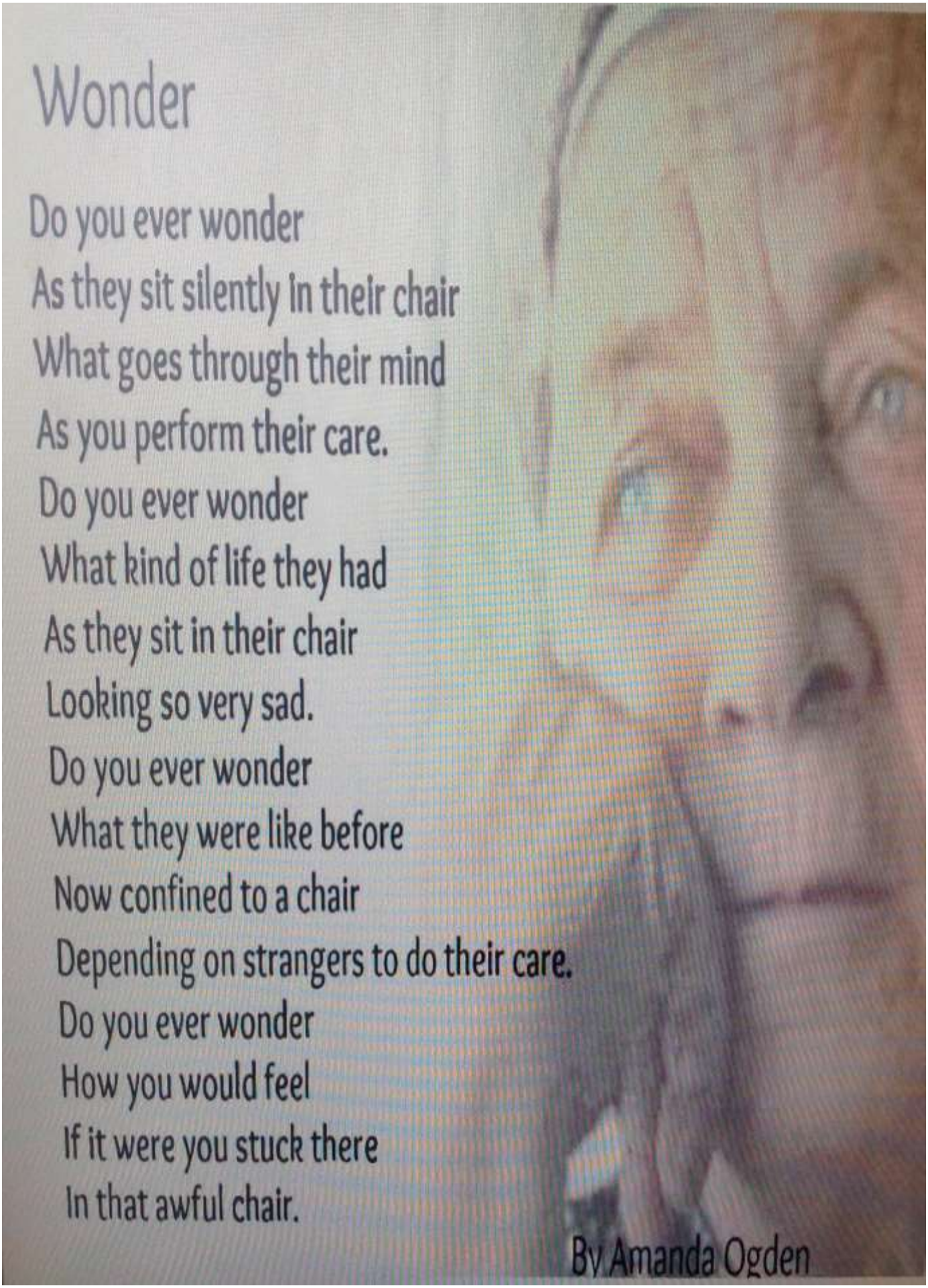
Have limited meaningful interaction

Sit alone, unable to access activities

Be somewhere that's lacking stimulation

OR

Would they like to live a life that has quality and meaning and engages them in their favourite activities, something as simple as sitting in the garden, in the fresh air, smelling the flowers and feeling the sun on their face?


Wonder
Do you ever wonder
As they sit silently in their chair
What goes through their mind
As you perform their care.
Do you ever wonder
What kind of life they had
As they sit in their chair
Looking so very sad.
Do you ever wonder
What they were like before
Now confined to a chair
Depending on strangers to do their care.
Do you ever wonder
How you would feel
If it were you stuck there
In that awful chair.
By Amanda Ogden