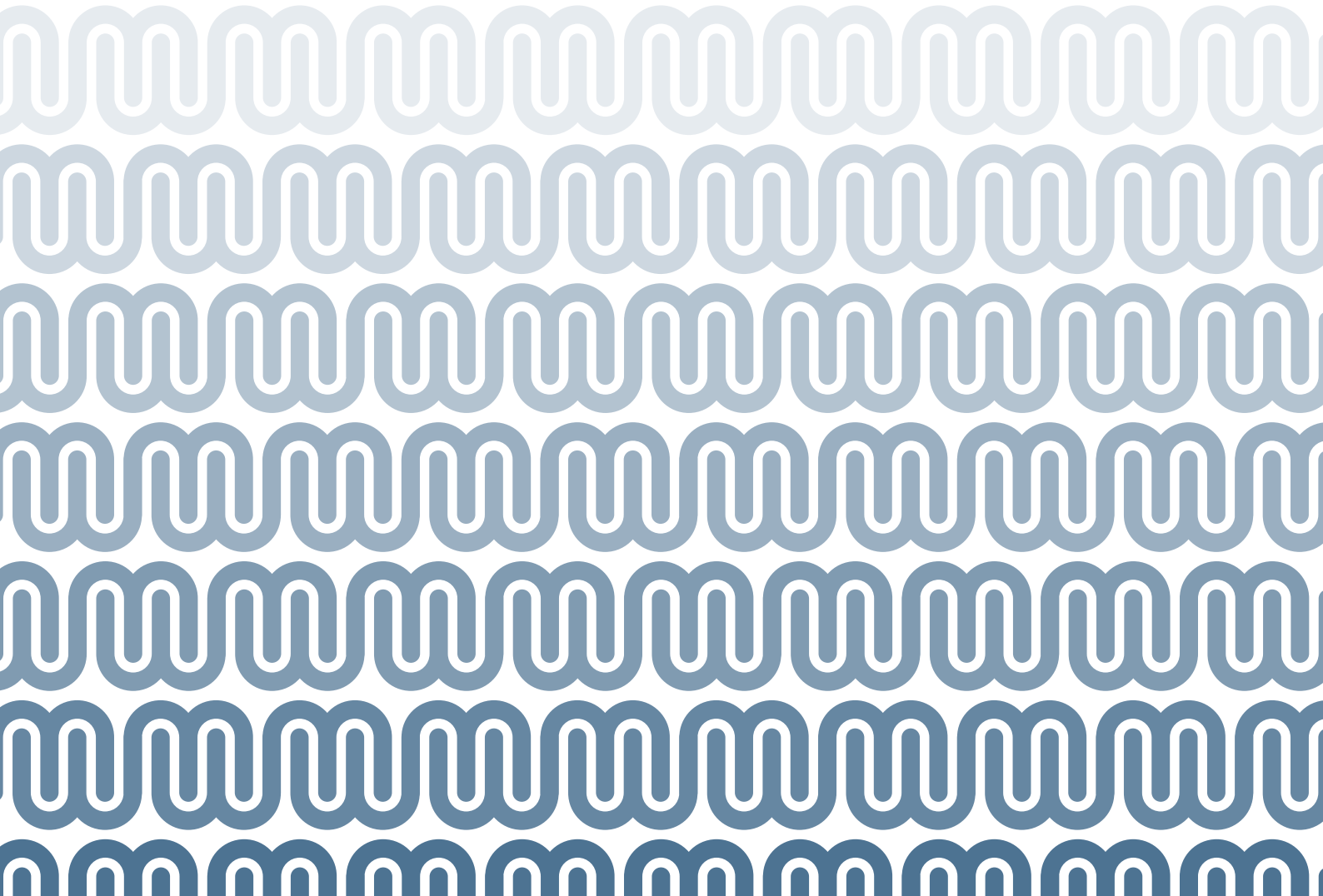
mental welfare commission for scotland

Scotland's mental health rehabilitation wards: themed visit report

Visiting and monitoring reports

30 January 2020



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

List of Recommendations

1) NHS Boards should consider seeking accreditation under the AIMS standards for in-patient mental health rehabilitation services, or benchmark their service against these standards, with particular attention to factors such as:
   a) Delivery of physical healthcare
   b) Participation in purposeful and meaningful therapies and activities which reflect the preferences of patients
   c) Evaluation of outcomes using structured measurement tools.

2) NHS Boards should ensure that no-smoking perimeters they have set around hospital buildings are clear to patients and staff, and that patients are supported to comply with no smoking policies.

3) NHS Boards should ensure that processes are in place at ward level to audit the prescription of medication for detained patients and the certification of this under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to ensure that all such treatment is properly authorised.

4) NHS Boards should develop plans to promote the knowledge and use of advance statements in rehabilitation services.

5) Integrated Joint Boards should review on an individual basis rehabilitation patients whose discharges have been delayed by over 3 months in order to develop a clear plan for discharge within an acceptable timescale.

Introduction

The Mental Welfare Commission regularly visits hospitals providing psychiatric care. We carry out local visits to look at the experiences of people receiving treatment in these wards, and we publish these local visit reports on our website. We also undertake themed visits, where we visit people using similar services across a short period of time, with key questions for patients, staff and visitors.

In this visit we focused specifically on NHS in-patients in rehabilitation services. The function of a specialist inpatient rehabilitation service is to help patients gain or regain the skills and confidence needed to progress their recovery. Inpatients in rehabilitation services are likely to have severe and complex mental health needs and will often have spent months or years in hospital which significantly affects their skills and abilities needed to live back in the community.

Since 2011 the number of rehabilitation beds had decreased from 421 to 309. We visited 130 patients. We did not include patients in continuing care beds since we felt this was a different patient group.

Why we did this themed visit

This themed visit was arranged because it is some time since we looked at rehabilitation, which is an important element in the spectrum of mental health services. Over the past 16 years we have undertaken a number of themed visits to look at the mental health care and treatment of people in relation to rehabilitation:

- In August 2003 we published *Greater Expectations*[1] which reported on our visits to 350 patients across 18 continuing care and slow stream rehabilitation wards for people with severe and enduring mental illness. We saw large institutional wards where patients slept in dormitories with limited personal possessions and personal space. We also found a lack of reviews of care and treatment. There was a lack of activities or community engagement for patients.
- In *Greater Expectations Revisited* (2009)[2] we reported on a series of visits to 159 people in rehabilitation and continuing care wards. We found that some patients were spending more time out of hospital, and more were now attending reviews, and being involved in care planning. However, ward environments had not improved and were unfit for purpose. We recommended NHS boards set admission criteria for wards in order to prevent the emergence of resident groups with widely disparate mental and physical health care needs.
- In *Living with severe and enduring mental illness in Scotland* (2016)[3] we interviewed 59 people who were living in the community, and were receiving care, treatment and support from community mental health services. Generally individuals living in the community were positive about the level of support they received from professionals.

[1] Mental Welfare Commission for Scotland (2003) *Greater Expectations* https://www.mwcscot.org.uk/sites/default/files/2019-06/Greater%20Expectations.pdf
[2] Mental Welfare Commission for Scotland (2009) *Greater Expectations Revisited 2009* https://www.mwcscot.org.uk/sites/default/files/2019-06/Greater%20Expectations%20revisited%202008.pdf
[3] Mental Welfare Commission for Scotland (2016) *Living with severe and enduring mental illness in Scotland* https://www.mwcscot.org.uk/sites/default/files/2019-06/living_with_severe_and_enduring_mental_illness_in_scotland_report_final_2.pdf

They felt listened to, having a consistent person to engage with, and felt that services were responsive with supports increased when necessary.

In comparison with acute inpatient services where the length of stay is short (averaging 40 days in the inpatient census for Scotland) the length of stay for people in rehabilitation services is much longer (582 days) and a higher percentage are likely to be detained under the mental health act (73% of patients in rehabilitation wards compared with 43% in acute psychiatry wards.[4] Given these differences and the impact on people of being in hospital for a prolonged length of time, we wanted to visit all rehabilitation services to review the standard of care in these wards and to hear from patients about their experience of being treated in a rehabilitation service.

We visited 22 wards in 15 hospitals between June and September 2018 and met every patient who was able and willing to talk to us. We spoke with staff, and reviewed case files and drug prescription sheets, including those of patients we had not been able to talk with.

We also spoke to 26 family members to find out their experiences of the care and treatment of their relative.

What we expect from a rehabilitation service

Over the past decade hospital inpatient bed numbers for the treatment of people with mental health conditions have decreased considerably across Scotland[5] in keeping with service changes across the UK. The reduction has applied to all types of inpatient beds and has been accompanied by an increase in spend on community mental health services.[6] While many people continue to benefit from these changes, which can be experienced as shorter admissions to hospital and greater support when out of hospital, some people at points in their life require longer spells in hospital and further specialist help to achieve the best recovery possible for them.

Rehabilitation services are most associated with this process of helping people achieve the best functional recovery they can. There are different definitions of what makes a service or inpatient mental health ward a 'rehabilitation service'. Although all inpatient wards will have a focus on recovery[7] we like the Royal College of Psychiatrist's definition of a 'rehabilitation service':

> "A service to help people recover from the difficulties of longer-term mental health problems. It will help and support people who still find it difficult to cope with everyday life or get on with other people. It will aim to help individuals deal with problems, to get confidence back, and to help them to live as independently as possible."

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[4] Scottish Government Annual Inpatient Census 2019
https://www.gov.scot/publications/inpatient-census-2019-part-1-mental-health-learning-disability-inpatient-bed-census-part-2-out-scotland-nhs-placements/pages/5/

[5] National Adult Mental Health Benchmarking Project 2017/18
https://www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/Mental-Health-Dashboard.asp

[6] National Adult Mental Health Benchmarking Project 2017/18
https://www.isdscotland.org/Health-Topics/Quality-Indicators/National-Benchmarking-Project/Mental-Health-Dashboard.asp

[7] Refer to recovery definition at Recovery Network
https://www.scottishrecovery.net/what-is-recovery/

Rehabilitation services are commonly led by Consultant Psychiatrists whose training may have included an 'Endorsement' from the Royal College of Psychiatrists indicating that they have interest and expertise in the treatment of people using a rehabilitation model of care. They work closely with a multi-disciplinary team.

When people are treated in a rehabilitation service we would expect that they have access to a multi-disciplinary team that has the requisite skill mix to deliver care that is focussed on rehabilitation.

In addition to the skills of psychiatrists and mental health trained nurses, there should be input from occupational therapists, clinical psychologists and primary care specialists or other doctors competent in overseeing the management of physical health co-morbidities. Rehabilitation teams should also have formalised access to input from dieticians, physiotherapists and speech and language therapists. We looked for evidence of patients having access to these core specialists in the planning and delivery of their care.

There are established good practice standards for rehabilitation services e.g. Royal College of Psychiatrists.[8] In common terms these standards are called the 'AIMS Rehab Standards' and offer a recognised, rigorous and supportive quality assurance, and accreditation process for mental health services. Although we did not set out with the expectation that all services would have obtained this accreditation status we believe that the Royal College of Psychiatrists process describes a useful set of standards/guidelines for services to aim for in the delivery of high quality care and treatment to people in rehabilitation services. There is only one service currently accredited in Scotland which is in Greater Glasgow and Clyde NHS.

Rehabilitation services are where we expect to see person-centred care at its best, reflecting the following features:

- **Rehabilitation care plans should be personalised** with clear evidence of the involvement of individuals in their creation and delivery.
- **Staff will work with and get to know a much smaller number of patients and should be supported to be able to work optimally with each individual** e.g. ensuring that they are given enough time to fully enact the elements of each patient's care plan and have access to ongoing training and continuing professional development of relevance to this specialist area of work. For example, education for staff on current methods of drug testing.
- **The inpatient environment in which rehabilitation centred care and treatment is delivered should be fit for purpose** encompassing easy access to the multi-disciplinary input required for optimum recovery. The environment should respect the dignity of individuals and reasonably conform to the same safety requirements as other wards. People whose length of stay can be up to many months will be disproportionately affected by the negative impact of a poor environment where this exists.
- Being an inpatient for long periods can leave people vulnerable to being disconnected from the routine healthcare delivery that they might receive at home. It is important that **people who spend long periods of time in inpatient rehabilitation services do not miss out on important physical health reviews, and are able to access national**

[8] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/rehabilitation-wards-aims-rehab/aims-standards-for-inpatient-mental-health-rehabilitation-services-third-edition.pdf?sfvrsn=a55d0883_2

screening programmes. Their healthcare should include lifestyle and wellbeing advice both opportunistically and as a core element of their care plan.

- We expect to find that most people treated in inpatient rehabilitation services would be on medication for the treatment of mental illness such as schizophrenia, bipolar disorder or severe depression. Some people might also receive medications for additional mental health conditions such as anxiety or obsessive compulsive disorder, as well as co-morbid physical illnesses. We were interested in seeing the range of treatments inpatients were being given and in **ensuring that treatments were prescribed safely with physical health monitoring in place where this was needed**. We also looked at what medications were being given to people who were detained under the Mental Health Act and we checked if this was **covered by the appropriate permissions and documentation**.
- We expect to find evidence of **independent advocacy** services involved with patients to assist in the promotion of their human rights. All patients have the right to access advocacy. We expect specialist inpatient rehabilitation services to have individualised **activities** to promote recovery demonstrated by activity planners/timetables. We also expect to see **family and carers fully involved** in the rehabilitation process where the patient desires such involvement.

How we carried out visits

We wrote to every NHS Board chief executive informing them of our planned visits to rehabilitation wards across Scotland. We asked them to confirm the location and current number of rehabilitation beds in their area. We informed them we wanted to hear the views and experiences of patients and carers about the care and treatment they were experiencing. We then wrote to these wards and arranged the visits.

We sent information to the ward managers so they could inform patients and relatives about our visit, and asked them to keep a note of anyone who wanted to meet with us. This information included posters, and leaflets for carers so they could think about what they wanted to tell us. Carer questionnaires were also left on the ward and these were completed and returned at the time of the visit or completed via a telephone call with a Commission visitor. We used a data collection templates for staff and for individual patients to capture the information contained in this report. We also looked at clinical notes and drug prescription/recording sheets.

General findings – how many people etc

Since 2011 we found that the number of rehabilitation beds had reduced by approximately one third. Of the 130 patients visited, just under 100 were subject to compulsory treatment. The majority of the patient population were adults aged between 25-64 years.

Age	Numbers
16-24	7
25-44	48
45-64	66
65-84	7
85+	2
	130

Patients were aware of their rights and knew how to exercise them by contacting advocacy services or their solicitor. Although there was considerable variation on the length of stay, we were disappointed that over a third of patients had been recorded as delayed discharges. This is an unacceptably high number.

We also found considerable variations in the length of stay for patients in rehabilitation services.

Length of Stay	
0-3months	12%
3-6months	9%
6-12months	22%
1-2years	20%
2+ years	37%

Key findings

- Services who were using core elements of the AIMS Standards for Inpatient MH Rehabilitation Services found them extremely helpful.
- Patients care and treatment in rehabilitation services is set at the individual's ability to progress to the next stage in recovery. For some this could be several months however, others may require much longer timescales.
- Joint working between hospital and community services is of critical importance to the success of discharge planning.
- Discharge planning works best when all disciplines are actively engaged in delivering the personalised care plan.
- Recurring elements which delay discharges appear to be lack of community resources such as appropriate accommodation and/or care packages.
- As people spend long periods of time in rehabilitation wards compared to acute inpatient wards, the importance of experiencing good relationships with staff in a supportive culture and atmosphere is magnified for everyone.
- We found a lack of updated care plans following on from admission to the rehabilitation service, and rehabilitation goals lacking definition and detail.

Recommendation one

- NHS Boards should consider seeking accreditation under the AIMS standards for in-patient mental health rehabilitation services, or benchmark their service against these standards, with particular attention to factors such as:
  a) Delivery of physical healthcare
  b) Participation in purposeful and meaningful therapies and activities which reflect the preferences of patients
  c) Evaluation of outcomes using structured measurement tools.

Staff and team resource

What we expect to find

- The AIMS standards set out what the staffing levels and skill mix should be for a defined number of beds in a unit. We expected that each service we visited would have daily access to a range of professional input including a consultant psychiatrist in rehabilitation, as well as medical, nursing, occupational therapy, and psychology staff. We also thought that there should be involvement from other allied health professionals such as pharmacy, dietetics, and physiotherapy.
- We wanted to find out if there was specific training and supervision for staff working in rehabilitation, as we anticipated that staff should have the basic principles of rehabilitation and recovery-orientated practice which is required in their role.

What we found

In addition to the 130 patient reviews, information gathered from a questionnaire completed by the Senior Charge Nurse of each service, prior to our visit, provided us with details of the staff team. It also noted what training and supervision was available in each service. We were able to gather this data for 20 of the 22 services.

Nursing

Each ward that we visited had both registered nurses and health care assistants providing patient care. Nursing staff work a range of shift patterns across the services; some do three eight hour shifts, more commonly known as an early, late and night shift pattern, others work a two shift system of 12 hours, or long days.

Some services have their nursing staff provide a mixture of these shifts, as well as having a shift that works across the day i.e. starting at 9am and finishing at 5pm; this helps to facilitate the patient's engagement in activities.

We found that the ratio of patients to staff that occurred most of was 3:1, the range went from a 1.25:1 (NHS Highland) to a 5:1 (NHS Fife). The AIMS standard is for every 14 patients, there should be at least one registered nurse and one healthcare support worker.

The Scottish Government also has processes that support agreed standards for safe staffing levels (ISD national workforce planning tool and safe staffing levels guidance) and the recommendations from these should be applied by all services.

We found every patient we reviewed had consultant psychiatry (Responsible Medical Officer, RMO) input (100%, n=130). For most services, the RMO was available two or three times per week, on weekdays, with a quarter of the services having daily input and a small number with weekly input.

Other medical input that was offered was from specialist trainees and GPs. Nearly all services had this input (17 out of the 20 services that provided details) which ranged from daily to weekly. There were two services that had no junior medical staff and one where referrals could be made. This was similar to the GP service on offer where a quarter (n=5) were referral only. However, we did find that in nearly half of the service, GP input was available as a regular session on, at a minimum, a weekly basis.

Occupational Therapy was the next most frequent professional group to be involved with rehabilitation patients. We found that more than ¾ of those patients whose care we reviewed (84%, n=109) had ongoing involvement with either an OT or an OT technician, or in a few cases,

both. All of the services reported having an OT in the team, with nearly three quarters of the services having them in the units on a daily basis. It was noted that the service was available during weekdays.

Less frequently involved was psychology. We found that fewer than half of the patients had input from psychology (41.5%, n=54) although access was possible in nearly all of the units; only one service had no psychology service. The availability of psychology ranged from a daily to a weekly basis, with less than a quarter of wards having to use a referral only process.

Other professional groups and or services that were regularly noted to be involved were activity coordinators, pharmacy, physiotherapy, dieticians, speech and language therapists, independent sector support staff and social workers. Some of these had weekly input to the rehab units, most were by accessed by referrals made via the clinical team.

We asked about the involvement of peer support workers and found that in more than half of Health Board areas, this was not on offer (n=11 out of 20 services). In those that could access peer support workers, this was a referral only service. We feel this is an area Boards should consider developing.

Training and Supervision

We found that all services offered a range of training and development opportunities for staff. In broader terms, these related to individual and team continuing practice development (CPD), psychological interventions, recovery-focused approaches and health and wellbeing training for clinical staff.

- **Individual/team CPD opportunities** included: operational meetings, journal clubs, business meetings, quality improvement groups and development sessions.
- **Psychological interventions and therapies** offered by staff included: behavioural activation, behaviour family therapy, mentalisation based therapy, psycho-social interventions, cognitive behaviour therapy, cognitive remediation therapy, decider skills, mindfulness, psychosis training and complex case formulation.
- **Recovery approaches** included: Connect to Recovery (NHS Fife), Wellness and Recovery Action Plans (WRAP)[9] and Reinforce Appropriate, Implode Disruptive (RAID) training.[10]
- **Health and Wellbeing courses**: ECG training, understanding issues with capacity, Clozapine initiation and treatment and a range of mandatory LearnPro modules that all NHS staff are required to complete.

All units reported opportunities for staff to engage in supervision. Types of offer were managerial supervision, reflective practice, low intensity psychological therapies supervision, clinical supervision and peer support. There was variation in who provided the supervision – it was noted that this was either offered by the Senior Charge Nurse, Charge Nurse or registered nurses in the unit; we also found that psychology staff were involved in supporting clinical supervision and reflective practice sessions. Supervision was offered on both on a 1:1 basis and in a group and where the frequency was defined, it was usually offered every four to six weeks.

[9] https://mentalhealthrecovery.com/

[10] https://www.apt.ac/raid-training.html

Care Plans

What we expect to find

- We were interested to find out about the care plans that were developed in rehabilitation. We expected rehabilitation services to have based their care planning following a comprehensive rehabilitation assessment.
- We wanted to see if the care plans were comprehensive, given the whole systems approach that rehabilitation uses. We expected to find care goals that included physical, psychological, mental, therapeutic, financial, social, recreational and vocational needs; we also expected the care plans to take into account the needs and strengths of the individual. We wanted to review the use of specific assessments for both rehabilitation and for risk.
- We also wanted to know whether the patient had their own copy.
- The Commission published good practice guidance on personalised care plans in August 2019.[11]
- When we were able to meet with patients, we asked if they felt involved in the planning of their care, if their strengths were recognised and if their family/carers were involved not only during their stay in hospital, but also with the care plan.

What people told us about their care plans

Of the 130 patients we reviewed, nearly all had a care plan in place. We found two patients who had no care plan.

We were interested to find out if patients had their own copy of their care plan. We found that only a few patients had their own copy (20%; n= 26), with more than half not having a copy of their plan (52%, n=67) and for the remaining there was no record of whether they have this (28%, n=37). We found one service where most of the patients had copies of their care plans (67%, n=4) (Russell Park/NHS Forth Valley); for the remaining services, only a few patients had a copy.

However, in some rehabilitation wards, we were told that patients could request a copy, or were offered a copy, but declined. We heard that patients would sign the documents that related to care plan goals; that regular 1:1 sessions with clinical staff/keyworkers were used instead of a copy of the care plan; that weekly timetables were used instead of care plans; and that the care plan was shared with the patient. One health board (HB) had previously provided patients with copies of their care plan, however, confidentiality of these documents was an issue, and the HB changed its policy due to data protection concerns.

Where care plans have been developed in collaboration with the patient, and reflect their individualised need, the patient should be offered their own copy of this in a format of their choice. As noted in the MWC good practice guide on care plans, people want a record of what they want to achieve during their stay in hospital.

Those that we spoke to about their care plans gave a range of experiences about their involvement and understanding of their care plans. We were told “I know what is happening with my care plan – there’s cooking, budgeting and a support worker to help me” (patient in NHS Fife). A patient in NHS Grampian told us “I’m happy with my current care plan. It includes my hopes to go to college” and a comment from a patient in one of the services in NHS Greater

[11] https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Glasgow and Clyde was “I have a copy of my care plan which I’ve been involved in drawing up. My family have been involved in my care while I’ve been in hospital and will be my main support on discharge.”

For others, they said “I’ve been a bit confused about my care plan and what was happening, but now I’m giving up my flat and will be staying in hospital for a while” (NHS Fife) with another patient from NHS Grampian who said “I didn’t know there was a care plan, but I do have time with my named nurse.”

Most of the specific comments we had about care plans were positive (69%, n=18), where we heard that the patient had time with staff to review and engage in the care plan process.

What we found in the care plans

Focus on rehabilitation

The AIMS standard for assessment requires that a patient has a comprehensive multi-disciplinary assessment of their:

- mental health and medication;
- their psychosocial needs;
- their strengths and weaknesses;
- their physical health;
- their risks;
- and should include a formal assessment of their daily living skills.

We wanted to gather evidence of the assessments undertaken by staff at the time of admission to an in-patient unit. We found that at least one formal rehabilitation questionnaire had been used in half of the care plans (51%, n=66); the standard would indicate that all patients in a rehabilitation service should be comprehensively assessed. The measures that we found included:

Measure/Questionnaire used in rehabilitation service	Number of patients*
Integrated Care Pathway (ICP)	24
Model of Human Occupation Screening Tool (MOHOST)	11
Recovery Assessment Scale (RAS)	9
Social Functioning questionnaire (SFQ)	7
Behavioural Status Index (BEST)	6
Psychosis Evaluation tool (PECC)	6
Avon Mental Health Measure	4
Brief psychiatric rating scale (BPRS)	3
Camberwell assessment of need (CAN)	5
Life-skills Checklist	2
Recovery STAR	2
Addenbrooke's Cognitive exam (ACE-III)	1
Clinical Institute of Withdrawal Assessment of Alcohol (CIWA)	1

**Total =81; some patients had more than one type of assessment in their file*

We were told that a range of other questionnaires were used across different health boards. These were:

Health Board area	Assessments used:
Ayrshire and Arran	My view
Fife	My view, Global Assessment of Functioning (GAF), Glasgow Antipsychotic Side effect Scale (GASS)
Forth Valley	My view
Greater Glasgow & Clyde	My view
Grampian	RAID
Lothian	GASS
Tayside	GASS, Adolescent/Adult Sensory Profile

Care plans

Most of the care plans we reviewed were comprehensive (72%, n=93); this included information about the needs and strengths of the patient.

Comprehensive care plans we saw included a range of the following topics:

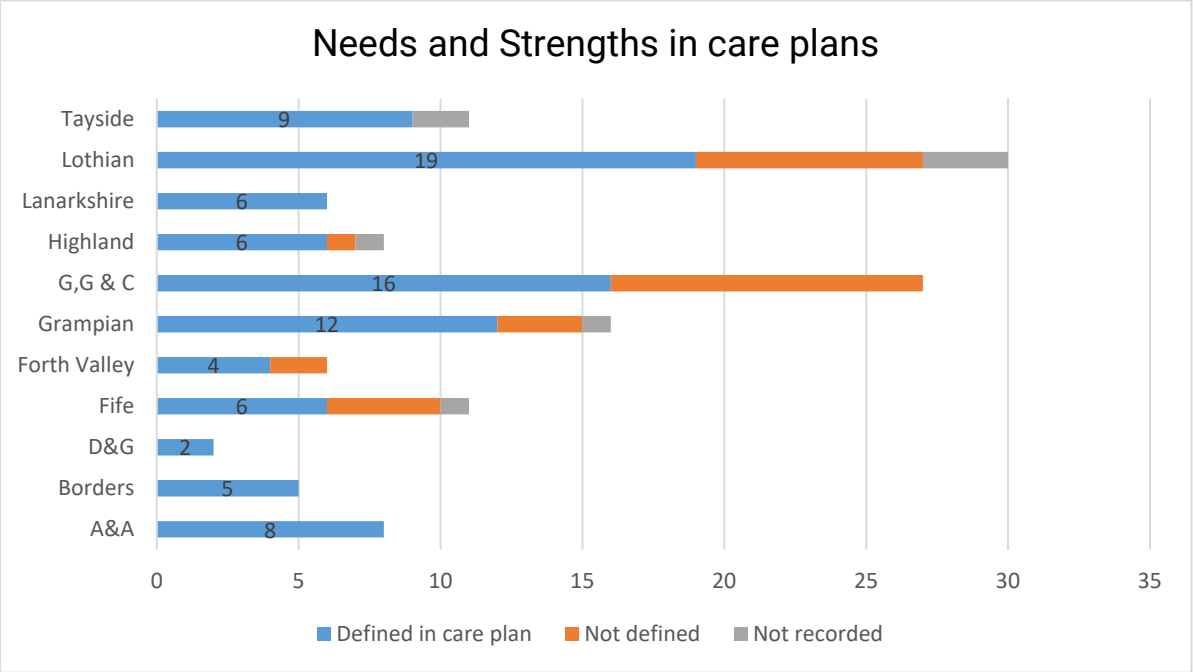
- Managing behaviours
- Maintaining a safe environment
- Requirements associated with the MHA
- Medication management
- Physical health
- Mental health symptoms
- Social vulnerability/maintaining personal welfare
- Level of independence and areas where support is needed
- Personal care needs
- Family involvement
- Planning for discharge.

Each health board area had developed their own care plan documentation. Some care plans had been developed from generic documents used throughout the HB mental health service. Issues that we found included a lack of update of care plans following on from admission to the rehabilitation service, and rehabilitation goals lacking definition and detail. The AIMS rehabilitation standards indicate that the documentation in care plans should be updated according to clinical need; when a patient is admitted to a rehabilitation service, their care and treatment is in relation to the skills they will need to develop while in this setting; assessments and management plans should be changed accordingly.

We also found care plans that were person centred, with a clear focus on recovery, using standardised approaches to care plans, such as *My View*,[12] personal support plans and rehabilitation integrated care pathways (ICPs) (NHS Lothian).

We found that some care plans considered the needs and strengths of the patient (NHS Grampian/NHS Lanarkshire). Having this as a defined section meant that clinical staff focused specifically on this particular aspect.

[12] http://www.healthcareimprovementscotland.org/programmes/mental_health/my_view.aspx



There were four HBs where 100% of the care plans we reviewed included the needs and strengths of the patient – NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway and NHS Lanarkshire.

We asked about carer involvement in the care plan process. Overall, half of the patients that we spoke to indicated that their carers were involved in the care plan process (51%, n=66). For some there was no carer involvement (26%, n=34), and in a few cases, we found that this had not been recorded (23%, n=3).

Where there was carer involvement noted, it was mainly because that family member was in contact on a regular basis. Their involvement often extended to attending multi-disciplinary meetings, and having their views recorded as part of the care plan process (see Carers Section).

People that we spoke to about their carers being involved told us:

> *My mum comes to see me and has spoken to my doctor, so she has her say. The level of input with my mum suits me.*
>
> *I meet with my named nurse where we go through my care plan and I get to sign this.*
>
> *My mum is involved – she's my named person.*
>
> *My family are very involved in my care plan. My mum is in twice a week and my brother visits every month.*

For a few patients, contact with family was not considered to be helpful due to traumatic family dynamics. For others, contact with the family was restricted due to various reasons such as the ill health of parents, geographical difficulties and in some cases, limited or no contact was at the request of the patient.

Risk Assessment

The section of care plans that was completed most consistently by clinical staff was the risk assessment. Across all of the services that we visited, we found that nearly all patients (95%, n=124) had one.

The detail in the risk assessments varied across health board areas. We found that in several services, patients' files contained safety plans (NHS Borders/NHS Grampian), some had trigger sheets for the management of crisis (NHS Lanarkshire), some used Red, Amber, Green (RAG) alerts with an associated action plan (NHS Tayside) and some had well developed risk management plans (NHS Fife). Others used additional assessments for risk; for example, in NHS Greater, Glasgow and Clyde, the Glasgow Risk tool accompanied their standardised risk assessment and in NHS Highland, STORM[13] was used. NHS Lothian had developed a part II of their ICP, which included the risk assessment and associated safety plan.

Evidence of reviews

We looked at whether care plans and the goals identified in them were reviewed by the multi-disciplinary team, how often this took place and whether the patient and their carer (if involved) participated in the process.

We found that nearly all of the care plans were reviewed anywhere between one and six weeks. Almost half were reviewed every week (, n=54) with a very few being done at six week intervals. A good practice example of this was the weekly MDT review conducted by NHS Fife, where a separate colour coded sheet, that had sections for mental state, physical health, medication, activities/ADL/OT assessments, psychology, social issues and identified risk was discussed at the clinical team meeting.

In addition to the weekly reviews, we also found that there were interim, three or six monthly reviews, done through the ICP process where the health board used this. Some services used the Care Programme Approach process to conduct annual review. An example of this was the NHS Lothian ICP where we found that goals on mental health presentation, activities, engagement/ functioning, medication, physical health, risk, substance misuse and passes out of the ward were all reviewed with patient and carer involvement.

Most of those that we were able to speak to on the day of our visit were able to tell us about the plans they had for moving on, and where they hoped to be in the future. One patient told us "I'll be returning to my flat. I like being part of the community. I want to be in better health and with SAMH (Scottish Association for Mental Health) – it's good for me. I need the support, I need the professionals around. I know the SAMH people pretty well; they're good people."

[13] https://stormskillstraining.co.uk

Physical Healthcare

It is well recognised that people with long-term mental health problems experience an increased incidence of physical health problems and major inequality in terms of life expectancy. People with severe mental illness are likely to die on average 20 years earlier than the wider population.[14]

The relationship between physical and mental health is such that poor mental health is linked with a higher risk of physical health problems, and poor physical health is linked with poor mental health.[15]

Most people in rehabilitation services are receiving medication for the treatment of illnesses such as schizophrenia, bipolar disorder and severe depression. Side effects of necessary psychotropic medication can cause or worsen physical health conditions e.g. due to weight gain caused by some medications.

Being an inpatient for lengths of time which exceed six months or even a year can leave people vulnerable to being disconnected from the routine healthcare delivery that they might otherwise receive if living at home. In the community, mental health teams will assist people with severe mental illness and co-morbid long-term physical health conditions to attend outpatient and primary care reviews.

It is important that people who spend longer periods of time in inpatient rehabilitation services are not disadvantaged by missing out on important physical health reviews and healthcare that they might receive if living at home. It is also important that they have access to national screening programmes. Their healthcare should include lifestyle and wellbeing advice given both opportunistically and routinely. The largest preventable component of premature death for this group is smoking.[16]

What we expect to find

- Systems to provide annual physical health checks for all patients.
- Patients having the same access to NHS national screening programmes that they would have in the community i.e. breast, cervical and bowel screening.
- Access to specialist alcohol and drug misuse services.
- Patients being provided with healthy lifestyles advice and support to be able to make healthy lifestyle choices.
- A ward culture supporting healthy lifestyles, particularly in respect of diet and exercise, and opportunities to exercise.
- Patients being provided with smoking cessation support and advice, including availability of nicotine replacement therapy.

[14] RCPsych
https://www.rcpsych.ac.uk/improving-care/public-health-and-its-role-in-mental-health
[15] Mental Health Foundation. Parity of Esteem.
https://www.mentalhealth.org.uk/a-to-z/p/parity-esteem
[16] RCPsych position statement *The prescribing of varenicline and vaping (electronic cigarettes) to patients with severe mental illness,* December 2018.
https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps05_18.pdf?sfvrsn=2bb7fdfe_4

- Patients who have long-term physical health conditions should have care plans that detail their physical health needs and their care and treatment for these. This may include assisting the patient's self-management of the condition.

What we found:

Annual physical health checks

The current Scottish Government mental health quality indicators say that people with severe and enduring mental illness should have an annual physical health check.[17]

In 17 wards staff told us that routine annual physical health checks were carried out. Doctors involved in carrying out these health checks included GPs and hospital doctors.

> *Ward has a visiting GP who monitors physical health care along with RMO passport to health in place.*
> MWC visitor, Lindores ward, Stratheden

In another ward staff said that individuals' health needs are continually assessed and physical monitoring regularly undertaken.

In two wards for which we do not have staff questionnaire data, we found evidence of annual physical health checks being undertaken among patients we saw there:

> *Good physical health check sheet used on unit - reviews need for optician, dentist, well man screening, etc completed.*
> Commission visitor, individual visit report, Pentland Court, St John's Hospital

> *Annual health check comprehensive and recently completed.*
> Commission visitor, individual visit report, Rannoch Ward, Murray Royal Hospital

Staff in one ward said there could be issues with availability of a doctor to undertake the annual health check, but this was done if a doctor was available. The Commission visitor recorded that this was "Sporadic and not consistent due to current unavailability of ward doctor/on-call doctor."

In one ward we were told that no routine annual physical health checks are undertaken.

We do not have information about annual physical health checks in the remaining ward.

It is good that most of the wards visited had clear processes for undertaking annual physical health checks. However, we are concerned to have heard from staff in two wards that these are not always done.

Ensuring that processes are in place for annual physical health checks to be undertaken, conducting audits to ensure that these happen, and acting on those audits, are local responsibilities. We did not seek to determine whether or not all the patients included in our visit had had a physical health check in the previous year.

Screening in line with national screening programmes

We asked staff whether patients have access to standard health screening (i.e. bowel, breast and cervical screening).

[17] Scottish Government mental health quality indicators. https://www.gov.scot/publications/mental-health-quality-indicators-background-secondary-definitions/pages/8/

We were told that this was available in 16 out of the 23 wards (NB we do not have a staff questionnaire for one of those wards).

> *GP audits national screening and refers.*
> Staff Questionnaire, Kelvin House, Gartnavel Royal Hospital

We gathered that there were issues with access to screening in the ward where there was reduced availability of doctors for annual health checks (as above).

In the ward where no routine annual physical health checks were undertaken, the Commission visitor recorded "National screening is only accessed if patient visits home to get letter." We were very concerned about this.

We do not have information about whether access to national screening programmes is available in the other four wards.

It is good that we found clear arrangements in place in the majority of wards for all patients to access to health screening in line with national screening programmes. On the day of the visit we expressed that we were very concerned that they were not complying with annual physical health screening. We advised that this should be rectified.

Management of physical health conditions

Practitioners were asked to record whether the patients reviewed had any long-term physical health problems. We specifically recorded when any of the following long-term conditions were present: high blood pressure, diabetes, asthma, gastrointestinal problems. When other physical health problems were present, we documented what those were.

- We recorded that 56 out of 130 patients had one or more long-term physical health problem (43%).
- 43 (77%) of these 56 patients were recorded as having one long-term health problem, eight (14%) as having two, and five (9%) had three.
- 21 people were recorded as having diabetes, seven gastrointestinal problems, five people high blood pressure, and two asthma.
- 32 people were recorded as having other long-term physical health problem(s). As would be expected, this included a wide range of medical conditions e.g. epilepsy, macular degeneration, osteoarthritis, psoriasis.

Care planning and treatment for chronic physical health issues

Where a patient had a long-term physical health issue, we were interested to see whether this was addressed in their care plan. For the 56 patients we recorded as having a long-term health problem, we considered that this was fully addressed in the majority and partially addressed in a few cases.

> *Good care plan for managing Type 2 Diabetes and education around self-management.*
> Clyde House, Gartnavel
>
> *Good evaluation of health care issues through ICP.*
> Braids Ward, Royal Edinburgh Hospital
>
> *Attends podiatry regularly to treat the effects of chronic neuropathy on her left foot, and medical staff regularly review her foot.*

No concerns were raised by our practitioners about the management of physical health conditions for people seen. We saw good examples of physical healthcare and input from other medical specialties as appropriate.

However, for some patients this could have been better represented in their care plan. Patients who have long term physical health conditions should have care plans that detail their physical health needs and the care and treatment for these.[18]

In a few cases the practitioner recorded that the care plan did not address the long-term physical health problem:

> *Not addressed in care plans but addressed at reviews e.g. reference to chronic constipation - follow up with gastroenterology referral and bowel screening and abdominal CT scan.*

> *Not addressed in care plan but medical notes have correspondence with cardiology as he was referred to this specialism by his RMO.*

We asked patients we interviewed whether they had any comments about their health and any long-term physical health conditions.

Of the 56 patients with long-term physical health problems, 18 spoke about their health conditions and/or treatment they were receiving.

> *His skin condition is related to stress and anxiety. He also has diverticulitis and has spoken with psychology and the OT about anxiety issues. They have given him advice and support and exercises and tools to manage his anxiety. He has weekly sessions with psychology which is very helpful in getting to the root of his problems and understanding the causes.*
> MWC practitioner record of discussion with patient, Ward 7B, Woodland View

Only one of these individuals made a negative comment about their healthcare:

> *Complaining recurrently about back pain and 'not getting seen for it'. Paracetamol and NSAIDS not helping.*

Five patients who were not recorded as having long-term physical health problems made comments about physical symptoms or conditions. Two mentioned symptoms that they said were side effects of medication. Two people spoke about significant current health issues.

> *I have stopped using heroin since admission. I have had tests for epilepsy as I have been having fits.*

> *Only issue about her leg. She is still in pain and she was being taken to A&E for review. She was worried she might have to have another operation.*

No patients discussed with us experiencing significant health problems that were not being addressed.

[18] https://www.mwcscot.org.uk/sites/default/files/2019-11/PersonCentredCarePlans_GoodPracticeGuide_August2019_6.pdf

We were pleased to see good examples of physical health care. We did not come across situations where patients were experiencing current health problems and not receiving adequate treatment.

Physical health conditions were not always explicitly covered in the patient's care plan. We appreciate that this does not mean that a patient's physical healthcare needs are not being met. However, it is good practice to include plans for the management of physical health conditions in the patient's care plan.

We particularly noted that NHS Greater Glasgow and Clyde has a comprehensive local policy for provision of physical healthcare for inpatients in mental health services. This includes screening, physical health monitoring and management of long-term physical health conditions. This is good practice.[19]

We suggest that inpatient rehabilitation service should benchmark and audit delivery of physical healthcare against national standards such as the RCPsych's AIMS Standards for Inpatient Mental Health Rehabilitation Services (see Recommendation 1)[20] or agreed local policies.

Treatment available for patients to address alcohol/substance misuse issues

Staff in almost all wards told us that they can refer patients to local specialist alcohol/substance misuse services.

> *Psychology 1:1 sessions, liaising with addiction colleagues and 1:1 sessions with Named Nurse.*
> Staff questionnaire, Ailsa Ward, Stobhill Hospital

> *Can be referred to drug and alcohol services but more liaison required.*
> Staff questionnaire, Amulree, Murray Royal Hospital

> *We can refer patients to Addiction Liaison Team whilst in hospital and thereafter refer for an addictions worker in the community. We also have a separate service called the Integrated Alcohol Team who support people in the community at their homes.*
> Arran Ward, Dykebar Hospital

Support/arrangements in place for people who smoke

We expect to see continuing efforts to provide patients with information, smoking cessation advice and encouragement. Patients who smoke may need to try a variety of options to support their efforts to cut down or quit.

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[19] NHS Greater Glasgow and Clyde. *Physical Healthcare Policy.*
Access to view this policy can be requested from the Clinical Policy, Guidelines and Improvement Manager, NHSGGC Mental Health Services

[20] RCPsych *Accreditation for Inpatient Mental Health Services (AIMS) Standards for Inpatient Mental Health Rehabilitation Services: Third Edition*
https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/rehabilitation-wards-aims-rehab/aims-standards-for-inpatient-mental-health-rehabilitation-services-third-edition.pdf?sfvrsn=a55d0883_2

Ward teams and specialist smoking cessation services should remain updated on advice and guidance such as the RCPsych's position statement on the safety and benefits of prescribing varenicline to patients with severe mental illness who smoke and want to stop.[21]

All wards offered smoking cessation support, often including input from specialist smoking cessation services to the ward. Nicotine Replacement Therapy was offered.

> *"We have a monthly smoking cessation group completed by smoking cessation team."*
> Arran Ward

> *"Clients can be referred to Smoking Matters smoking cessation service if they wish. Designated smoking area in garden. Designated persons on each ward who are point of contact to discuss referral. Patient should be asked on admission if they smoke and wish to stop."*
> Staff questionnaire, Dalveen ward.

We asked patients we interviewed "Are you a smoker and have you had help to manage this?"

Of 74 patients interviewed, the majority said that they smoke (45).

Just over half of the people who smoke did not refer to cutting down, wanting to stop, having engaged in smoking cessation or using e-cigarettes. A third of those people mentioned having had smoking cessation advice. A third said they did not want help to stop.

> *He currently smokes: "they wanted me to quit, I said no." He has had advice around different options available to assist him in quitting and he has had specialist nurses speak to him but he goes out and smokes and this is what he does with his time and doesn't wish to stop.*

A minority of people who smoke referred to having tried to cut down or having used nicotine replacement without success (20%).

> *Yes - don't want to stop. I have tried the patches but I am allergic to them.*

Just under 20% of people who smoke referred to having cut down considerably and/or using nicotine replacement or e-cigarettes.

> *I am a smoker but have cut down drastically - I will sometimes not smoke for two to three weeks. I use vapes.*

While a lot of work has been done across services to provide health promotion around the risks of smoking, and smoking cessation support, a lot of patients do still smoke. A significant number of these patients say they do not want to stop smoking. This is an important risk to health.

We collected information about where people can smoke for 19 wards within hospital sites. Whether patients could smoke in the ward garden, hospital grounds, or only off the premises was variable. In 13 of those wards we were told by staff that patients smoke in the grounds

[21] RCPsych position statement *The prescribing of varenicline and vaping (electronic cigarettes) to patients with severe mental illness.* December 2018. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps05_18.pdf?sfvrsn=2bb7fdfe_4

or saw evidence of this. In nine of those 13 wards patients smoked in the garden or just outside the ward (or, in one hospital, wards actually smelt of smoke).

We are concerned that patients in a significant number of the wards visited are smoking in areas near the ward that the Board have determined should be smoke-free. The Scottish Government is currently holding a consultation on prohibiting smoking outside hospital buildings.[22]

Recommendation two

- NHS Boards should ensure that no-smoking perimeters they have set around hospital buildings are clear to patients and staff, and that patients are supported to comply with no smoking policies. Initiatives to support healthy lifestyle choices

We asked staff about initiatives in the ward to promote healthy lifestyle choices and provide dietary advice, weight management and opportunities for physical activity.

Across wards there was a strong ethos around supporting people to be able to make healthy lifestyle choices and engage in exercise. We have chosen some examples.

> *Encouragement with advice re healthy diets in menu planning. Strong emphasis in physical activity. Bikes available in ward and range of opportunities to be involved in physical activity.*
> Bruar Ward, New Craigs Hospital
>
> *Clients are weighed weekly and the MUST tool used to review. General dietary advice available from staff and specialist referral to dietician available. Gym available on site for those that can use it. Exercise groups run in the ward.*
> Dalveen, Midpark Hospital
>
> *Healthy eating information available. Healthy lifestyle group planned includes smoking cessation. Gym equipment purchased and funding bikes.*
> Braids, Royal Edinburgh Hospital
>
> *We have a food, fluid and nutrition group which staff attend, patients are involved via their community meeting when staff feedback current topics, patients have been given questionnaires with regard to their likes and dislikes and staff feed these comments back to the kitchen staff. Patients have highlighted the need for more fresh produce and better quality vegetarian food, changes have already happened and food sent is of a better standard although there is still some way to go. We have a walking group, gym group, badminton and bowling group, all weekly. Individual patient like walking and do so around the gardens on a daily basis. Healthy Lifestyles Group which OT organised looks at weight management and healthy eating and preparation. Nursing staff organise health food group incorporated with an activity, patients made fruit kebabs and health snacks; this is ongoing.*
> Glencairn, Coathill Hospital

[22] The Scottish Government *Prohibiting smoking outside hospital buildings: consultation*. https://www.gov.scot/publications/prohobiting-smoking-outside-hospital-buidlings-consultation-paper/pages/3/

What people told us about exercise

The importance of physical exercise to benefit health is clearly well known, and covered in national guidance.[23] We asked patients "In the last week (7 days) have you done any physical exercise for more than 20 minutes", how often they had done so, and what exercise they had done.

Of the 64 patients who responded, the majority said they had undertaken one or more episode of exercise lasting more than 20 minutes. A minority of them had done this more than three times in the last week, and a few only once.

A few people said they took little or no exercise. Half of them explained that they were unable to exercise much due to physical health problems, e.g. arthritis, back pain.

The most commonly mentioned regular exercise taken was walking: around the grounds, to the shops or elsewhere in the community, walking groups. Other exercise people mentioned included exercising in their room (sit ups, push-ups, squats), gardening, going to the hospital gym or other gyms, cycling, boxercise, swimming, football, exercise class, tai chi, karate and badminton.

> *Walks to the beach and around the grounds. It's a good ward for that sort of thing. They are always encouraging you to get out and about.*
>
> *Boxercise, walking group yesterday and it's on every Tuesday and Thursday. Staff will encourage you to walk further afield as well. Green gym gardening project and nature walks.*
>
> Two patients, Ward 7B, Woodland View

What people told us about their weight and weight management

We asked patients "Do you have any concerns about your weight and have you had help to manage this?"

Sixty-two people gave clear answers in respect of their views about their weight. About half of those patients said they had no concerns about their weight. Around a third spoke of being overweight.

> *I hate being overweight. I never used to be. It is the medication I am on.*
>
> *I put on weight when I went on the depot and I don't like being this size. I asked to go back on tablets rather than a depot but was told I can't. I am going to see a dietician to lose weight.*
>
> *I have a heart condition due to being overweight. I have lost 16 stone through healthy eating and exercise and would like to lose another eight stone.*

Comments that people made about help to manage their weight were mainly positive.

> *A bit overweight and staff do encourage me to go to the gym and eat healthier.*

[23] Start Active, Stay Active: A report on physical activity for health from the four home countries' Chief Medical Officers https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

I would say yes. The OT nurse has spoken about healthy eating and I try to buy a lot of vegetables and eat plenty of fibre.

A very few people spoke of not feeling that staff were helping them adequately with weight management.

I have put weight on and I would like to lose weight - staff don't help me with this. No exercise at all.

Yes - lots of weight gain on Clozapine. Not getting help to manage it.
(This person also said they do no exercise because of back pain)

Two people said they had lost weight and did not indicate that they still felt they were overweight.

Did put on a lot of weight but have watched my diet and increased exercise (I have a fit bit and aim to do at least 10k steps per day) and have lost two stones.

A few people had concerns about being underweight

Underweight – I see the dietician and am making sure that I build up my weight.

It is clearly concerning that around a third of the patients who discussed their weight with us had concerns about being overweight. This is not surprising in this patient group, with a particular factor being weight gain as a side effect of prescribed medications.

We were pleased to hear from some patients that they found support and advice from staff about weight management helpful, including specialist input from dieticians. Some people spoke of having successfully lost weight.

The fact that a considerable number of patients had concerns about their weight underlines the importance of rehabilitation teams continuing to provide appropriate advice and support around healthy lifestyles and weight management.

Treatment with medication for mental health conditions

Most people in rehabilitation services are receiving medication for the treatment of illnesses such as schizophrenia, bipolar disorder and severe depression. Many of these patients have illnesses that are complex to treat, and receive several different psychotropic medications.[24] This increases the level of medication side effects that people experience.

Side effects of psychotropic medications often impact on physical health e.g. metabolic effects such as weight gain, development of diabetes, and abnormal blood lipids leading to increased risk of cardiovascular disease. Sedation can lead to reduced energy and levels of exercise, which can lessen physical wellbeing.

It is important that medication reviews are regularly undertaken to ensure that medications are prescribed only at doses that the patient needs, and that monitoring for physical adverse effects of medications is undertaken.

The majority of patients in rehabilitation wards are receiving compulsory treatment under the Mental Health Act.

What we expect to find

- Patients who are prescribed high doses of antipsychotic medication receiving high dose antipsychotic drug monitoring, in accordance with RCPsych good practice guidance,[25] local protocols and Maudsley Prescribing Guidelines.[26]
- Psychiatrists undertaking regular medication reviews.
- Psychotropic medication prescribed for people detained under the Mental Health Act properly authorised with the necessary certificate in place where required.

What we found

128 patients (98%) were prescribed medication. Only two were not prescribed any medication.

For all patients who were prescribed medication for a mental health condition (i.e. psychotropic medication), we aimed to record those medications that were prescribed. We recorded this information for 124 patients.

The 124 patients for whom we have details of psychotropic medication prescribed were receiving one or more psychotropic medications prescribed regularly as per the table below.

[24] The term "psychotropic medication" can refer to any medication that has an effect on the mental state of the person who takes it. However, in this report, when we refer to psychotropic medication we mean medication that is prescribed to treat a mental health condition.

[25] RCPsych *Consensus statement on high-dose antipsychotic medication*. RCPsych College Report CR190, November 2014. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr190.pdf?sfvrsn=54f5d9a2_2

[26] *The Maudsley Prescribing Guidelines in Psychiatry*. D M Taylor, T R E Barnes, A H Young. 13th Edition. Wiley Blackwell, 2018.

Number of regular psychotropic medications	Number of patients
1	34
2	42
3	27
4	17
5	3
6	1
Total	**124**

118 (95%) of these patients were receiving one or more antipsychotic medication(s) regularly (i.e. medications commonly used in the treatment of psychosis). Of these, 83 were prescribed one regular antipsychotic, 34 two antipsychotics, and one was prescribed three.[27]

Fifty-two patients were receiving clozapine (44% of those who were prescribed a regular antipsychotic). This is to be expected in this patient group as clozapine is particularly used to treat people with schizophrenia whose illness is resistant to other medications.

Six patients were not receiving antipsychotic medications. Three were prescribed a mood stabiliser in combination with an antidepressant (one of these people was prescribed two antidepressants). Two were prescribed mood stabilisers (one of these people was prescribed two). The other patient was prescribed an antidepressant.

Visiting practitioners recorded that 31 people were on high dose[28] antipsychotic medication. Recorded dosages of regular antipsychotic medication did not amount to high dose antipsychotics in 11 of these cases. However, in some cases there was potential for high dose administration of antipsychotics with use of "if required" antipsychotic medication that was prescribed. There may have been some "if required" medication prescribed for others that we did not record.

We consider that it is good practice to implement high dose antipsychotic monitoring when the total prescribed medication that could be administered, including "if required" medication, would amount to high dose.

We found a high dose antipsychotic monitoring protocol in place for 29 of the 31 patients we recorded as receiving high dose antipsychotics. For one of the patients for whom we did not find a protocol, the practitioner noted that an electrocardiogram (ECG) and blood tests had been undertaken. The other was one of the patients who was not receiving regular high dose antipsychotics.

From the above, it appears that high dose antipsychotic monitoring is being routinely undertaken in line with best practice, as we would expect.

[27] The patient who was receiving three antipsychotic medications had had complex treatment requirements. Their Consultant recognised that the maintenance treatment plan was complex and unusual, and the need for careful physical monitoring. The treatment plan was being gradually rationalised.

[28] Antipsychotic treatment is "high dose" when the total dose of antipsychotic medication(s) exceeds the British National Formulary (BNF) maximum recommended dose. Conventionally, this is worked out by converting the dose of each drug into a percentage of the BNF maximum recommended daily dose for that drug and adding these together. A cumulative dose of more than 100% is a high dose.

Medication reviews

For all patients prescribed medication, practitioners checked whether medication had been reviewed in the past 12 months. 73 patients had been in hospital for more than 12 months. 71 of those patients were prescribed medication. The practitioner recorded that a medication review had been undertaken within 12 months in most of those cases, this was not answered in a few cases. We only recorded that we could not find evidence of a medication review in four cases.

Among the four patients for whom we did not see evidence of a medication review, a multidisciplinary team review was taking place weekly for two, and monthly for the other two. Three of these people were interviewed and said that they regularly saw their doctor. It seems most likely that their medication had been reviewed, but that this was not prominently recorded in key review documentation.

It is good practice that medication reviews are being carried out. We would encourage psychiatrists to record medication reviews clearly in key documentation where they can easily be found (such as multidisciplinary team meeting documentation and minutes of periodic reviews). It should be clearly recorded in the patient's care plan that this review has taken place.

Authority for treatment under the Mental Health Act

99 patients were subject to compulsory treatment under the Mental Health Act or the Criminal Procedures (Scotland) Act. All but one of them was receiving medication for their mental health.

We were pleased to find that all of these patients had consent to treatment certificates (T2) or certificates authorising treatment (T3) in place under the Mental Health Act to authorise treatment.

For 90 of these patients, we checked whether the T2 or T3 form properly authorised all of the psychotropic medications they were prescribed.

We recorded that there were no issues with authority for treatment with medication under the Mental Health Act for most of these patients.

In five cases the visiting practitioner recorded that there were issues with the T2 or T3 form they saw in the ward, but a MWC Medical Officer considered on review that treatment was appropriately authorised. (E.g. there was a more recent T3 form that the visiting practitioner was not shown; the problem identified was sub-standard wording of a T2 that we advised could be better).

Very few patients were prescribed medications that were not properly authorised (six people). Five were prescribed some medication that was not included on the T2 or T3 form in place. One was prescribed oral lorazepam "if required" with a higher daily maximum dose than the T3 authorised (the authority was up to the British National Formulary maximum dose). We raised this with staff in all of the cases, and asked for medical staff to review the treatment and arrange for proper authorisation if it was to be continued.

Recommendation three

- NHS Boards should ensure that processes are in place at ward level to audit the prescription of medication for detained patients and the certification of this under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003, to ensure that all such treatment is properly authorised.

Diabetes and Clozapine

It is to be expected that this patient group will have a high incidence of prescriptions of clozapine. Impaired glucose tolerance and emergent diabetes is a well-known side effect of clozapine.

As above, we found that 21 (16%) of all patients had diabetes. This was the physical health condition most commonly found. Most patients with diabetes were recorded as receiving one or more regular antipsychotic medication (18). Two were not. The other was a patient for whom we do not have information about prescribed medications.

Regular antipsychotic medication prescribed for 18 patients with diabetes		
Number of antipsychotics prescribed	**Number of patients**	**Antipsychotic(s) prescribed**
1	15	Clozapine (9) Zuclopenthixol decanoate (2) Risperidone (2) Quetiapine (1) Olanzapine (1)
2	3	Clozapine + sulpiride (1) Clozapine + aripiprazole (1) Zuclopenthixol decanoate + paliperidone depot (1)
	18 (total)	

As can be seen, 11 of these 18 patients with diabetes were receiving clozapine, either alone or with another antipsychotic medication.

These 11 patients represent 21% of the 52 patients we recorded as receiving clozapine.

The NHS Scotland Clozapine Physical Health Monitoring Standards include regular monitoring of fasting blood glucose. Our findings emphasise the importance of this routine monitoring.

Rights and Safeguards

Advocacy, advance statements and the management of funds

What we expect to find

- Services respect and promote the human rights of patients.[29]
- Patients being kept in hospital against their will should be legally detained.
- Patients have access to advocacy.
- Where patient funds are managed by the hospital there are robust mechanisms in place to safeguard patients' money and maximise patient involvement in the spending of their money.
- Advance statements are in patient notes and there is promotion of the use of advance statements.
- Any restrictions on freedoms are legally authorised.

What we found

Detained patients

The majority of the patients (76%) we visited were detained under mental health legislation. Most (70%) were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003; and there were seven patients detained under the Criminal Procedure (Scotland) Act 1995.

Eight of the patients we visited were also subject to welfare guardianship under the Adults with Incapacity Act (Scotland) Act 2000; this Act can authorise a range of powers but cannot authorise detention in hospital.

In our Greater Expectations Revisited report in 2009, only 61% of patients were being treated on a compulsory basis. The shift to the current situation of over 75% of patients now detained under mental health legislation hopefully indicates a better understanding of the requirement to use legislation to restrict human rights and provide the appropriate legal safeguards. Alternatively, others might view the reduction in bed numbers as having the effect that the patients who remain in hospital will be more ill, and therefore more likely to be subject to compulsory powers.

Helping patients understand their rights

Advocacy

The Mental Health (Care and Treatment) (Scotland) Act 2003 gives everyone with mental illness, learning disability, dementia and related conditions the right to access independent advocacy support. Patients in rehabilitation services are likely to have severe and complex mental health needs and often need support and assistance to promote their rights and help in having their voice heard in relation to their wishes with regard to their care and treatment.

AIMS standard 4.6, says patients are to be given verbal and written information on how to access advocacy services within the first four hours of admission. This is obviously important but access to advocacy requires to be an ongoing and central part of patient care to promote patient rights and autonomy.

[29] https://www.mwcscot.org.uk/sites/default/files/2019-06/human_rights_in_mental_health_services.pdf

Ward staff told us that they utilised multiple methods to ensure that patients knew about their rights and we found access to advocacy services available on all the wards we visited. Staff acknowledged that referral to advocacy services was helping patients understand their rights.

We found leaflets and posters were commonly available, and written information was provided from medical records if a patient changed their legal status.

Less commonly wards said that rights were regularly discussed in 1:1 meetings with a named nurse/keyworker, others said discussions about advocacy were generally covered by the patient's Mental Health Officer (MHO) or social worker.

We also heard from some wards that advocacy is discussed at recovery groups or at education/information sessions run by agencies invited to the ward.

From our contact with patients we found that most (110) were aware of advocacy and nearly all of these patients (107) were actively in contact with advocacy, mostly on a one-to one basis. Others said they had used advocacy in the past but felt no need for this support currently. A few patients were unsure about advocacy services but his was largely an issue of their capacity.

Patients indicated advocacy was helpful in relation to legal status and detention and for appeals and tribunals. Patients also mentioned advocacy being helpful at Multi-Disciplinary meetings (MDTs) and care planning meetings. We also heard that patients had found advocacy helpful for a range of other more general issues, such as a utility company.

We had a number of specific patient comments indicating the value of advocacy, such as:

> *He is very good. When I have a meeting I find it hard to speak up but he speaks up on my behalf. I find it easy to speak to him rather than a group of people.*

Patients also spoke of other people helping them when asked about advocacy including the named nurse, solicitors and family.

> *I like nurse to be around if I go to meetings.*
> Patient

Advance Statements

The Mental Health (Care and Treatment) (Scotland) Act 2003 allows an individual to make a written statement (an advance statement) when they are well, which sets out how they would prefer to be treated (or not treated) if they were to become unwell in the future. Advance statements are a powerful way of ensuring that people with mental health problems are listened to, even when they are unwell. Some people have found them to be very helpful but fewer people than expected have actually made advance statements. The Commission are now responsible for holding a register of all advance statements in Scotland. The Commission has produced Advance Statement guidance[30] which should be used in their promotion.

Health Boards are now under a legal duty to publicise the support they offer for making advance statements.[31]

[30] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf

[31] Mental Health (Care and Treatment) (Scotland) Act 2003 s276C (inserted by Mental Health (Scotland) Act 2015)

On our visit we found that 13 patients had made advance statements (clearly documented in the notes) and one was in process. Interestingly six patients we interviewed thought they had made an advance statement but did not have one and at least one person who had made one could not remember what was in it.

The majority of patients we interviewed were not sure about advance statements or had not heard of them.

We noted that when the MWC practitioner took time to discuss advance statements at least four individuals said they would like to consider making an advance statement.

There are likely to be a number of reasons for the low uptake of advance statements and the Commission is aware that some individuals think that it is not worth it as they will be overridden anyway; others have said that they do not wish to contemplate the possibility that they may become unwell again in the future. Some professionals and service users have also found them difficult to understand. We would encourage people to look at our guidance to see the benefits of making an advance statement.

We did hear comments on wards that indicate a lack of understanding:

> *Nursing staff don't really feel it is a vital part of their work with the patient whilst on the ward and should be considered more when the person is back with CMHT.*
>
> *The making of advance statements - this would be done by the advocacy service.*

Patients in rehabilitation services generally have severe and complex mental health needs and are patients who may relapse in future. We would expect that active promotion of advance statements should be part of the rehabilitation process.

The fact that the Commission found a small number of patients who may be interested in making an advance statement suggests a need for greater promotion in these wards.

NHS Boards and Integrated Joint Boards should ensure that they are delivering their responsibility to promote and encourage the use of advance statements in their area. Active local strategies need to be operationalised by managers.

Recommendation four

- NHS Boards should develop plans to promote the knowledge and use of advance statements in rehabilitation services.

Management of funds

A significant number of individuals we visited had difficulties with the management of their money. Many were able to do so with support but others had their money managed for them as they were judged to be 'incapable' of managing their own funds.

We found where money was being managed, that financial interventions were authorised either under the Adults with Incapacity (Scotland) Act 2000 (AWI) or Department of Work and Pensions (DWP) appointeeship.

All wards said their approach to management of money was part of care planning. Where possible individuals were given advice and encouraged to manage their own finances with the support of informal use of budget plans. Various terms were used 'Financial care plan', 'Voluntary Financial Support Plan', 'Spending plan', 'Budget plan'.

The Commission believes that, for someone who is unable to manage their own finances, better management of those finances, using existing guidance and legislation, can be an integral part of providing for their health and welfare.

> *My money is managed by hospital. I used to spend it all on food and taxis and I wasted it. Now it is managed. I am saving some of it and I hope to buy a new guitar soon.*
> Patient comment

The need to manage finances needs to be discussed as part of the care management role and appropriate measures considered, bearing in mind the principles of the Adults with Incapacity Act. These principles include the benefit to the individual, the least restrictive option and ensuring that, whatever level of skills the individual has, those skills are taken into account. The Commission has published a guidance document *Money Matters*[32] to assist in this process.

The most common financial intervention we saw on our visits was when patient's benefits were managed by a DWP appointee. Generally this was the hospital (NHS Patients' Funds) though there were situations of relatives or social work being the appointee. There were also situations where 'non benefits' funds were managed by the hospital under Part 4 of AWI.

Power of attorney was being used to manage funds in six cases we saw; three patients had financial guardians under the Adults with Incapacity Act.

Generally it was the named nurse who had the lead role in discussion with the patient about their finances and this was then discussed at the MDT or with the support team.

One ward said benefits were discussed on admission; another that social work was involved in order to access the 'income maximisation officer'; other wards said the 'Patients Affairs Officer' could give advice.

Where required, for example for help in managing debt, patients would often be referred to other agencies such as Citizens Advice Bureaux, local council benefit and inclusion officers, community agencies, social work and advocacy.

We asked how wards let people know what funds are available to them.

Where money was managed by the hospital, we found that patients generally had access to 'account statements' 'cash sheets' or 'monthly balances'. The balance or a statement could also be made available on request.

A minority (26 of 130) individuals managed their money solely by themselves or with help from their families.

> *I manage my money myself and I will be applying for PIP.*
> Patient

The majority (76%) had some direct input from hospital or ward towards managing their money, indicating the importance of this aspect of rehabilitation on recovery.

[32] https://www.mwcscot.org.uk/sites/default/files/2019-06/money_matters.pdf

Only a minority of patients (about a quarter) of the patients we visited had an active budgeting/spending plans, with the individual being encouraged and supported to develop budgeting skills.

We heard many comments such as these from patients.

> *I get £24 per week for food shopping. I get ESA fortnightly £230. Staff work with me to help me plan food shopping and menu planning and budgeting.*
>
> *I am limited to £9 each day – (used for cigarettes) – I would like more daily money.*
>
> *I am limited to £10.00 a day as I have to pay back an overpayment from DWP. I have a savings account at hospital and know how to access it. My named person has access to it too.*

In general when funds were managed by the hospital it seems that small amounts of patient money (about £50) were kept on the ward with any money over this (larger amounts) having to be arranged with patient funds.

Some patients had their own bank accounts and often went to get their money from the bank or cash machines during outings and shopping trips, such situations were frequently supervised.

We are aware that there can be situations for patients who have been in hospital for a long time; if not actively managed funds can accumulate. We believe it is important that patients can achieve the maximum benefit from their money. We did not specifically enquire about the issue of accumulating funds but had some comments such as:

> *His money managed by hospital – he gets £5 per day but currently has in excess of £10,000 and is being encouraged to buy new clothes. Service managers should ensure that money management be an essential component of care planning in rehabilitation services.*

Activity and recovery

What we expect to find

- We expected to see patients with a personalised timetable of activities with activities taking place in the community as well as on the ward. We expected to see patient preferences being taken into account during activity planning, a record of patient involvement in their activity provision and a good record of activity undertaken. We expected to find that patients being encouraged to achieve their own goals and advance their independence through the continuous promotion of therapeutic interventions.
- We also expected to see patients being offered activities to enhance daily living skills, access to creative activities, activities to promote health and exercise, educational opportunities and opportunities to leave the ward and access outside space on a regular basis. Activity opportunities should be provided seven days a week and out of hours.

What we found

Activity planners

From examination of the records of the patients we visited, we found that most had some form of personalised timetable of activities. These timetables varied considerably between patients and between the various wards; in fact it seemed there were often differences with regarding to activity planning for patients on the same wards. In the best situations patients generally had a weekly timetable covering seven days of activity, reviewed and designed with them on a weekly basis; patients should generally have a copy of their activity timetable.

> *Patient said they have a weekly activity timetable which they complete with their key worker every weekend*.
> Dalveen Midpark

Our visitors commented positively on the activity programmes for patients at Woodland View, observing that activity programmes were reviewed and designed weekly, with a good range of personalised activities. Goals were identified by the patient and they had a copy of their activity timetables.

Activity planners varied considerably between patients, from laminated sheets in patient notes to individual patient diaries which they completed themselves or with staff. Most had a varied programme of purposeful activity, though we saw many that were very repetitive and focused on self-care tasks. Activities listed included getting showered, getting dressed and laundry; some also listed activities such as getting medication and ward meal times in the activity planner.

The majority of patients had activity planners including weekend activities.

In terms of patient involvement we found that only a minority of activity plans demonstrated patient involvement in activity planning in their notes, specifically with planners being countersigned by the patients. It is important that participation in activity and evaluation of outcomes must be clearly recorded in combination with the activity planner.

From speaking with patients however it seemed evident that most had engagement with staff in relation to their activities.

Staff returns for all wards also indicated involving patients in their rehabilitation activities was a crucial element to involving and motivating patients in their recovery. One to one sessions with key workers / named nurse were mentioned in most returns as being very important to build up relationships with patients and to find out their interests and goals.

> *Goals discussed with patients to create collaborative goals.*
> Leverndale
>
> *Small achievable goals, praise and encouragement – involvement of family / carers.*
> Stratheden
>
> *Weekly timetable collaboration – using interest checklist – encouraging patients to do things they enjoy.*
> Bellsdyke
>
> *One to one sessions with Named Nurse and OT to establish areas of interest and incorporate this into activity timetable. Discussion with carers to establish areas of interest previously enjoyed by patient. If able patients are encouraged to sign care goals.*
> Stobhill

In relation to activity plans most patients had plans linking to their goals with only a minority of activity plans not being judged to include patient goals.

In addition to individual timetables, 17 of the wards also had a ward programme of activities with these being displayed in a communal area. These activities were generally group activities such as breakfast groups, walks or arts and craft sessions often OT or Activity coordinator led.

The way in which participation in activity was recorded and reviewed also varied considerably. In the majority of patient notes participation in activity was clearly recorded but in a minority of cases there was no record of whether or not patients actually undertook the planned activities. Very few patients were not engaging in activity and had no plans; there were a few patients where the situation regarding engagement in activity was not clear.

For most patients participation in activity was recorded in the daily progress notes / nursing notes. Notes often stated such things as 'patient went shopping or attended mindfulness group' but there was generally no outcome or evaluation of the activity or progress made or difficulties encountered.

We would expect that services with a focus on rehabilitation should be evaluating outcomes more systematically using structured measurement tools.

The Multi-Disciplinary Team meetings (MDT) frequently summarised patient activity over the previous week but rarely in relation to outcomes and evaluation of progress. We also noted very little to link the activity plans and participation notes for most patients; in fact from the progress notes it was not always clear if the patient had actually participated in the activity from the activity planner.

Activities

We heard from patients and staff of a wide variety of activities available. All the ward staff questionnaire returns indicated staff were helping patients develop personal care, domestic, shopping and budgeting skills along with coping with stress and managing crisis.

Ten of the wards we visited had a staff member in a regular activity coordination role, generally daily, mainly weekdays 9am – 5pm, but we found generally that on most of the wards nurses were doing most of the activity and outreach work.

> Activities are carried out by all staff and plans coordinated weekly.
> Polmuir
>
> *Flexi staff from nursing team are available nine to five to co-ordinate trips and facilitate personal shops each day nine to five.*
> Arran
>
> *Ward staff provide this as a service. Don't have someone in this role.*
> Clyde
>
> *0.5WTE activity nurse. Input allocated to the needs of individuals.*
> Fraser
>
> *Daily input from OT.*
> Glencairn

In some wards patients were able to access on-site activity provisions such as recreational therapy (RT) at Leverndale Hospital and the Beehive Centre in Woodland View.

From examination of patients' records we looked for evidence of the rehabilitation activities patients were involved in.

We found that the majority of patients were involved in activities to develop life skills, and about half in relation to budgeting. About one in ten had taken up some form of volunteering. We found very few examples of patients involved in more specific training, and only one had input in relation to becoming employed.

Patients interviewed supported our findings from patient records and indicated a focus primarily on daily living skills, physical activity, and craft and recreational activity.

As well as direct rehabilitation activities a minority of patients also said they were encouraged to participate in cultural activities such as church and religious groups, visiting local libraries, art galleries and attendance at music groups.

Opportunities to leave the ward and access outside space on a regular basis

We asked patients we interviewed when they last left the ward. Of those able to answer our question, most said they had been out of the ward in the last week and about half of them had been off the ward on the day of our visit. Very few patients had not left the ward for over a week.

We asked these patients what they had done when they had been out of the ward:

- 37% (20) had gone for a walk or exercise – 'out for fresh air', 'went for a cycle', 'went for a walk in the hospital grounds', 'went to the park', went to the gym; a few said they went for a walk to have a smoke; one walked to the 'bookies'.
- 28% (15) had gone to the shops or into town shopping, many of these patients had gone to get food in relation to their cooking activities.
- 13% (7) said they had been out with relatives either visiting them or being taken out by family – this highlights the importance of maintaining relative and care contacts.

- 13% (7) spoke of going on 'home passes' or to spend time at home as part of their planning for leaving the ward.
- 7% (4) had gone to volunteering activities.

Things patients would like to do but do not get the chance to do

In general most patients seemed fairly happy with their activity situation though some would have liked more sessions of things like swimming, more arts and crafts, gym sessions, more walking groups and outings; in general it seemed that expectations were low.

Several patients spoke of wanting to move on to their own accommodation and two spoke of being worried about their flats, having not been there for some time. Others wanted more time with their families. A small number of individual comments concerned staff being too busy, lack of internet access or wanting a holiday.

It is important to not lose sight of what is important in people's lives, for example, one patient wanted a chance to date and establish a relationship another wanted to the opportunity to attend college.

What community services do individuals access?

We asked services about what services they access in the community as this is an essential part of any rehabilitation activity.

We were pleased to see that all wards had very much embraced their local services and heard of a variety of initiatives and collaborations from all areas.

In all wards it seems patients are routinely accessing local services including: public transport, local shops and services including community dentists, optician, community GPs and hospital appointments. We also noted multiple examples of good use of local leisure, swimming and fitness facilities along with use of local cafes, banks, local community centres, parks and gardens.

Most areas had established links with local community groups and projects which were providing volunteer opportunities in a wide range of settings: cafes, animal projects, gardening projects, football initiatives, woodwork and picture framing projects as well as numerous other local initiatives.

Wards also reported links with community colleges and potential work placements though we saw very few patients actually undertaking education and work placements.

Overall, we were pleased to see the level of community opportunities that seem to be developing in rehabilitation services. This is a considerable advancement on our previous reports for inpatient rehabilitation services. However there is still scope to build on this progress.

In particular, rehabilitation services should be evaluating outcomes more systematically using structured measurement tools, and patient 1:1 time should be prioritised.[33] See Recommendation One.

[33] AIMS Standard 8.1.9 suggests a minimum of 1 hour per week.

Peer support

Peer Support is the help and support that people with lived experience of a mental illness or a learning disability are able to give to one another. It has been demonstrated that peer working is a powerful way to support and develop recovery focused practice.

We found very little evidence of the use of peer support workers in rehabilitation services even though it would seem this is a particular area of service where peer support may be valuable and appreciated by patients.

Very few patients we met (13) said they were aware of peer support and even fewer were actually in contact with a peer support worker. We encountered a lot of confusion from patients who mentioned general support from support workers, advocacy and patient support groups as peer support; some staff also seemed confused probably due to not having come into contact with peer support workers.

There seemed to be an interest in developing peer support but little evidence of peer support in action.

We did not have enough evidence on this visit of the impact of peer support to make a formal recommendation, but we would encourage services to consider whether greater use could be made of peer support workers in rehabilitation services and services developed.

Carers' involvement

What we expect to find

- We expect family and friends to be fully involved in the rehabilitation process as much as they and their relative are comfortable with.

What we found

Overall, the 26 carers we spoke to, all of whom were all family members, were positive about services in general, highlighting communication and support from staff in particular.

> *Staff are approachable, friendly and welcoming and available.*
> Glencairn ward Coathill

The lack of meaningful activity on the wards was the most common complaint from families.

> *Expected more activity. Days not stimulating enough.*

Most families we interviewed felt welcome on the wards and had access to appropriate private places to meet at visiting, and were able to go out of the ward with the patient.

> *We are always treated with respect when at the ward. Staff always make time to speak to us to give updates on our son. Staff are available if we need to report on him if his behaviour has been challenging.*
> Amulree, Murray Royal

Difficulties around visiting and going out were mainly due to illness of individuals.

The majority of families were happy with their involvement in the care and treatment of their relative but a few felt they were not involved at all. Most confirmed they were invited to reviews.

> *They listen to my opinion.*
> Amulree, Murray Royal

> *I generally get told rather than asked for my view.*

Updates were mainly provided by telephone although families were also given information at visiting and during meetings which was felt to be satisfactory by the majority of carers.

The majority of families were very or fairly satisfied with the care provided for their relative

> *Attention to all aspects of care. Family feel patient is safe and their needs being met. A clear plan in place as we move to discharge.*
> 7B, Woodlands View

Staff attitudes were specifically praised by 42% (11) carers.

> *Sensitive to individual needs Pleasant and welcoming. Good listeners.*
> Leverndale

> *Nursing staff are very pleasant and helpful, courteous.*

But some felt things could improve.

> *Psychiatrist - patronising - does not value family input. They are in total control of patient.*

Of those who commented on the availability of activity many felt these could be more varied and that their relative needed more encouragement and support to engage. Others were very complimentary

> *Yes. A full programme of activities. He enjoys physical exercise, cycling, walking and gym. Socially very engaged with family.*
> 7B Woodland View

> *Not at present. Needs more encouragement.*

Those individuals who had a discharge plan all had their relatives involved although none of their discharges were imminent.

We asked families how their relative's illness had impacted on them. The majority of carers responded and all described significant negative outcomes especially with family relationships.

> *Historically it has been devastating for the family. Long periods of no contact. He deteriorated in front of the family due to his chaotic lifestyle.*

> *He has lost touch with any friends he had. The condition has made him isolated as he no longer engages much with other family members/friends.*

We asked if the families could suggest something they felt would make a difference to the current care.

Providing more in the way of appropriate, meaningful activities was highlighted as a way to help individuals maintain their skills, leading to an increased chance of successful discharge. Support at that time and in the community were highlighted as being vital also.

> *Involvement in things he used to do, cycling, swimming, and walking.*

> *Needs good quality support in community by people who she has a relationship with.*

There were not many responses to our request to suggest one positive thing that would improve the situation for them but a few families actively praised the current care.

> *Nothing, this is a good service and there should be more of it.*
> Glencairn, Coathill

> *No, quite happy with ways things are going.*
> Rehab, Leverndale

In terms of support for themselves, most of the families had not been directed to any support and only a few had had an assessment of their own needs.

Environment

We found that the majority of wards seemed to be satisfactory but there were several areas identified that needed improvement. 16 wards were felt to be well maintained and decorated to a reasonable standard. However, of the remaining, six were unsatisfactory with some requiring considerable upgrading.

> *The mixture of active rehabilitation and slow-stream means very differing needs can be hard to meet in one ward.*
> MWC visitor comment

Patients in 15 wards were normally free to come and go but at the time of our visit three had locked doors due to individual risk assessments. Half of the patients had some form of restriction on leaving the ward.

Almost all patients had full access to their own rooms in the daytime. Eighteen wards had some access to outside space, within which 15 had extensive areas with some offering gardening opportunities. Two wards had no outside space.

Ward layout varied considerably. In 13 wards there were day areas available that could be designated as single sex. All of the patients were able to personalise their own space. 12 wards could provide single rooms with en-suite facilities, and a further 4 had either a single or a shared room but with adequate shower provision. However, six wards provided shared accommodation and inadequate shower provision.

Delayed discharge

On our visits we asked staff about delayed discharges. We found that 33% (39) patients had been recorded as a delayed discharge of whom the majority were male.

There were plans in place for more than half of the patients that we reviewed (n=67) to move on, however for a few patients (n=25) there were difficulties with plans around discharge. The main issues were caused by a lack of appropriate accommodation, fluctuations in the mental state of the patient, and delays in being allocated a social worker or in having access to funding for a package of care.

Joint working between hospital and community services is of critical importance to the success of discharge planning. This would be demonstrated by seamless joined up care. We note that these recurring elements such as the lack of community resources such as funding for care packages, and lack of accommodation. We would encourage commissioners of services to be mindful of the needs of these patients, and expedite the necessary resources timeously.

Discharges are best achieved when all disciplines are actively engaged in delivering the personalised care plan. As the patient is accessing their community they may also require access to some specialist community services e.g. community addiction resources. This may be influential in successfully completing and maintaining the discharge.

Recommendation five

- Integrated Joint Boards should review on an individual basis rehabilitation patients whose discharges have been delayed by over three months in order to develop a clear plan for discharge within an acceptable timescale.

Conclusion

In general there have been some improvements since our previous visits in assessment, care planning and reviews for patients in rehabilitation wards, although this is not universal across services. The extent to which patients access their local communities has improved and will assist the transition from hospital.

However, there is always a risk that this group fall by the wayside, as services focus on people whose needs present as more urgent or dynamic. This should be seen as a highly skilled area with expert staff and appropriate resources to help people who have often had difficult lives.

Maintaining hope and a focus on recovery over a long period is vital. In particular, services could be doing more to encourage patients to have a healthy active lifestyle which in itself promotes recovery. Services should continue to identify any resources that could be utilised to reduce delayed discharges and where necessary clearly identify ways to alleviate such delays.

References

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