Mental Welfare Commission for Scotland

Report on announced visit to: Oak Tree Ward, East Lothian Community Hospital, Alderston Road Haddington East Lothian EH41 3PF

Date of visit: 16 November 2020

Where we visited

Oak Tree Ward is a newly built older people's mental health ward in East Lothian Community Hospital. The service was previously based in Lammerlaw Ward at Herdmanflat Hospital, where it was a 16-bed mixed inpatient ward providing hospital based complex clinical care (HBCCC) for patients with dementia. We last visited Lammerlaw Ward on 14 January 2019 and made recommendations about managers reviewing documentation, carrying out case file audits, and ensuring that all patients receiving treatment under the Adults With Incapacity (Scotland) Act 2000 ('the AWI Act') had up-to-date documentation authorising their medical treatment.

At the time of the Commission's last visit, the move to the new ward was scheduled for September 2019. Prior to this, we were advised of a planned change in the patient population and remit of the ward. The new service would admit people over 65 with functional mental illness for assessment and treatment as well as patients requiring assessment for dementia, and this would be alongside the existing patient group who required dementia continuing care.

We had concerns about these changes, which we shared with senior managers. We wanted to hear about the plans to manage the needs of these diverse patient groups and an informal visit to the new ward, Oak Tree, took place in November 2019. At that time, we shared our view that the ward environment and staffing required further consideration. Initially, when the ward opened, only patients requiring continuing care for dementia were admitted.

In spring 2020, the ward began to admit patients with functional illness and those requiring dementia assessment. This happened before the planned environmental adaptations had taken place.

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. The Commission has undertaken a phased return to our visit programme following Scottish Government recommendations.

This visit was arranged to follow up on the previous recommendations, and to meet with patients and their relatives, to review their care and treatment throughout the period of the pandemic, and to find out how the new ward environment was working in practice for this mixed patient group.

Who we met with

We met with and reviewed the care and treatment of seven patients and three carers.

We spoke with the chief nurse, the service manager, the senior charge nurse (SCN), charge nurse, the consultant psychiatrist, higher trainee, and other staff on the ward.

Commission visitors

Claire Lamza, Interim Executive Director (Practitioners)

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

The patients and family members we spoke with were very positive about the care being provided on the ward. They were complimentary about nursing staff. One patient described the staff as “amazing”, and said that many went “above and beyond” to provide support.

We heard from a relative who spoke about visiting restrictions during Covid-19, and the frustrations this caused. This has been a very challenging year for patients, carers and for staff. In general we heard that the changing rules and restrictions on visits in particular had been sensitively and supportively managed. When physical visits have not been possible, staff have supported patients to contact their families by phone or by using technology.

We noted changes in the staff team since our previous visits. There is a new permanent SCN, supported by two deputy charge nurses and a number of additional new staff have also been recruited. The staff we met with were engaged and enthusiastic, and we noted a positive change from previous visits.

Patient files were in the process of being transferred to TRAK electronic records. The majority of documents were easily accessible electronically, whilst a few were kept on paper in ward files. The paper files were neat and organised. We saw good use of ‘Getting to Know Me’ forms, providing information about the individual from their families.

Care plans addressed physical and mental health needs. There were some good examples and we noted that this was an area of practice that was undergoing further improvement work. Care plan documents should be reviewed regularly and updated where appropriate. This will be particularly important for supporting patients on the ward with stress and distressed behaviours. We look forward to seeing further progress on future visits.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

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

There was good documentation of weekly ward rounds on TRAK, which included a list of those present at the meeting, with detail of the discussion and a clear action plan was provided.

We thought that risk assessment documentation would benefit from review and that individual patient risk should also form part of the weekly ward meeting record. This is particularly important in light of the patient mix and the risks for some patients, particularly those with a history of harm to themselves. We noted that this was a concern for a number of patients on the ward at the time of our visit, who had presented with a risk of suicide at the time of admission.

We were also aware of a recent serious adverse event of the ward involving a patient with dementia. We discussed the case with clinicians involved and were advised that processes for communicating risk information from the community to the inpatient team at the point admission were being reviewed and improved.

There should be a clear risk management plan, with decisions documented about observation at the point of admission, and including enhanced mental health risk assessments where appropriate.

Recommendation 1:

Managers should ensure that current risk assessment processes and documentation are reviewed and comparable with those used for NHS Lothian patients admitted to older adult wards at the Royal Edinburgh Hospital.

Recommendation 2:

Managers should ensure that a patient's risk history is available at the point of admission and every patient has a comprehensive risk assessment completed on admission that summarises their individual risk profile and informs their observation status on admission.

We recommend that ongoing risk issues are reviewed and documented at the weekly ward round.

The multidisciplinary team includes input from an occupational therapist (OT) and OT assistant. Two activity co-ordinators had recently joined the team. Input from other professionals including dietetics, speech and language therapy, and physiotherapy, can be arranged on a referral basis.

There was still very limited access to psychology support. We were told that referrals could be made on a case-by-case basis, but that, due to waiting lists, patients were unlikely to be seen whilst in hospital. This is a significant gap in service provision, especially in view of recent changes in the patient group.

Recommendation 3:

Managers should review psychology provision for the service and ensure arrangements are in place for inpatients who require this support.

We noted that since the retirement of the former consultant psychiatrist, the clinical lead post for the service had remained vacant. A number of concerns had been raised with the Commission prior to the visit in relation to line management and governance arrangements for senior medical staff. We recommend these issues are addressed by senior managers.

Use of mental health and incapacity legislation

Copies of documentation relating to the Mental Health (Care & Treatment) (Scotland) Act 2003 and the AWI Act were present and accessible for the patients we reviewed.

When an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law, and provides evidence that treatment complies with the principles of the AWI Act. Many of the patients on the ward were subject to the AWI Act and were unable to consent to their medical treatment. We found s47 certificates in place, accompanied by treatment plans. Where patients were taking covert medication we saw evidence of covert medication pathways, though in some cases the timescales for review required clarity.

Rights and restrictions

During our visit, we noted that there was access to a local advocacy service and that support could be accessed by referral. It is important that this is well publicised and that patients are aware of this service.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We heard that this was an area where progress was being made. The recent appointment of two activity co-ordinators will enable the provision of activities for patients on the ward seven days a week. The recent weekly sessions from a music therapist, funded through an endowment fund, had been extended for another six months and managers told us they were hoping to make this a permanent arrangement. Funding has also enabled the ward to buy equipment to support individual activities.

Individual patient notes referenced engagement in activities including music therapy and OT sessions on the ward, as well as outings with family or staff, at times when this had been possible during Covid-19. We look forward to seeing further progress in this area on future visits. We also acknowledge that meeting the needs of the diverse patient group will be a challenge.

The physical environment

The new ward provides a bright welcoming environment, with large open plan communal space and quiet areas around the ward where patients can sit if they choose.

The needs of the now-diverse patient group are difficult to meet in one ward, particularly when activities take place in the open plan lounge-dining area.

There is a small activities room with craft supplies and a further room on the ward that has been designed as a salon, where patients can enjoy hairdresser visits and beauty therapies from staff.

The bedrooms are located along two parallel corridors, which are used separately for male and female patients when this is possible. Each bedroom has an en-suite shower room. There are 16 bedrooms in the main area of the ward. We noticed that all of these rooms had obvious potential ligature points. While the concern for patients with dementia is accidental self-harm, it is a concern for patients who may present with an increased risk of suicide. We were told that an environmental audit had been carried out and that patients were individually risk assessed; if there was a concern, observations would be used to address any potential environmental risks.

We were also shown a four-bedded area that adjoins to the ward which was intended to be used as a separate area for the care of patients with functional illness admitted to Oak Tree. Whilst these bedrooms were considered to be safer, we were still concerned about the presence of ligature points. There appeared to be a lack of clarity as to when this new clinical area would be ready for patients. We were concerned by suggestions that the beds could be occupied within days of our visit. Aside from potential environmental risks, we were unclear how this separate area was intended to function as a stand-alone therapeutic unit. Arrangements for dining, recreational and therapeutic activities, and the physical spaces in which these would take place, did not appear to be finalised. It was our view that further planning with the clinical team was required to detail how this unit would work, be staffed and deliver a high level of care, treatment and support to a vulnerable and potentially high risk patient group.

We raised these concerns with senior managers following the visit. We have been advised since that further planning and design has taken place and that funding is being allocated to develop this separate unit. The Commission wish to be kept updated of plans and timescales in this regard.

Recommendation 4:

Senior managers to fully review the plans for developing a separate unit for patients with functional mental illness, and to advise the Commission of timescales and measures that have been put in place for safely managing the current diverse patient mix on Oak Tree Ward.

Summary of recommendations

1. Managers should ensure that current risk assessment processes and documentation are reviewed and comparable with those used for NHS Lothian patients admitted to older adult wards at the Royal Edinburgh Hospital.

2. Managers should ensure that a patient's risk history is available at the point of admission and every patient has a comprehensive risk assessment completed on admission that summarises their individual risk profile and informs their observation status on admission.

3. Managers should review psychology provision for the service and ensure arrangements are in place for inpatients who require this support.

4. Senior managers to fully review the plans for developing a separate unit for patients with functional mental illness, and to advise the Commission of timescales and measures that have been put in place for safely managing the current diverse patient mix on Oak Tree Ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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

CLAIRE LAMZA
Interim Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.
The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.
Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details:

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

telephone: 0131 313 8777
e-mail: mwc.enquiries@nhs.scot
website: www.mwcscot.org.uk