Mental Welfare Commission for Scotland

Report on announced visit to:

Vaara & Ythan Wards, Rohallion Clinic, Muirhall Road, Perth PH2 7BH

Date of visit: 10 & 11 October 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Rohallion clinic is a forensic in-patient unit incorporating both low secure services and medium secure services based at Murray Royal Hospital, Perth, which provides forensic care for patients from the North of Scotland. Vaara and Ythan Wards are both 12-bedded medium secure rehabilitation wards. On the day of our visit, Vaara had no vacant beds and Ythan had three vacant beds.

The unit has a multidisciplinary team (MDT) comprising of nursing staff, psychiatrists, psychology, dietetics, occupational therapy (OT) staff and allied health professional staff.

We last visited this service on 9 September 2019 and made a recommendation regarding a review of the seclusion suite, however we note that this recommendation was not actioned.

During our visit we wanted to follow up on the previous recommendation and hear how patients, staff and relatives have managed throughout the Covid-19 pandemic.

Who we met with

We met with seven patients and reviewed the care and treatment of eleven in total.

We spoke with the senior charge nurses (SCNs) on both wards, the head of nursing and, at the end of the day, we met with psychiatrists, psychology staff, the general manager and the quality improvement lead.

Commission visitors

Alyson Paterson, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met with during our visit were mostly positive about the staff on the wards. They were described as very approachable, we were told that staff find solutions to problems and that they treat patients with dignity and respect. Some patients felt that they would benefit from more one-to-one time with nursing staff.

Feedback from patients regarding food on the ward was mixed. Some patients were positive about the choice and quality of food and told us that it was freshly cooked on site. Others were less positive and complained about the small portion sizes.

Many patients were unhappy about not being able to use their own laptops. Some individuals were able to use their own laptops during lockdown; however this practice has been paused and is currently under review. We fed this back to staff at our end-of-day meeting and we were advised that the service is looking at ways that patients can safely use their own laptops. We are looking forward to hearing how this develops.

Many of the issues raised by patients were in relation to their personal concerns. We provided advice on the day of our visit and, if appropriate, fed back any concerns to staff.

Care plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. NHS Tayside have produced a set of standards, Mental Health Nursing: Standards for Person Centred Planning. We were advised that the service undertook a care plan audit in July 2022 and identified significant concerns. As such, a quality improvement plan is in place looking specifically at care plan structure, review and patient involvement. A further audit is due to take place at the end of October 2022.

During our visit, we found it difficult to locate care plans on the electronic patient record system, EMIS. The care plans we did see did not give us a sense of the individual or the progress that had been made. They lacked detail in terms of what specific interventions were required to meet the desired outcome. There were too many separate care plans and there would be benefit from amalgamated these into one document as is the practice in other in-patient wards in Tayside. Care plan reviews did not appear to review the original care plan and overall they were difficult to read. We would expect to find detailed summative reviews that targeted nursing intervention and individual's progress to meet specific goals.

Some documents that were recorded as care plans were more processes e.g. providing payment to a relative who was visiting. Overall the quality of the care plans we saw was inconsistent.

Some of the patients we spoke to did not feel that they had participated in their own care planning although some felt that they had been involved. The language used in the care plans was rather prescriptive and we would have hoped to see a change to more person-centred language and reference to patient's views captured in their care plans. If a patient does not wish to engage in care planning or does not agree with the goals and interventions identified,

their reasons should be clearly recorded. Some patients told us that they would like to have a copy of their care plan.

Recommendation 1:
Managers should ensure that care plans are person-centred and detail clear interventions and outcomes. They should evidence patient participation, be regularly reviewed and their quality audited.

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/node/1203

Multidisciplinary Team (MDT)

A range of professionals were involved in the provision of care and treatment in the wards. This included nursing staff, psychiatrists, psychology, dietetics, occupational therapy (OT) staff and allied health professional staff. We were told that there were more than eight vacancies across the two wards. Staffing was at an even more critical point a year ago, and agency staff were being employed for six-month blocks.

We heard that clinical team meetings were held every two weeks. Care and treatment was also reviewed under the Care Programme Approach (CPA). The CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. For certain groups of patients, an enhanced CPA can be used as a mechanism for regular review of their care, treatment, needs and risk management. We were pleased to see enhanced CPA used on both wards and found the information contained in this document to be accessible, detailed and containing clear evidence of patient participation.

We saw that some patients had a cognitive-behaviour formulation which consisted of five key stages known as the Five P's model. This supports staff and patients to look at the current problems or issues the person is facing, to get a clear understanding of what they are and then set goals or targets based around this. The formulations we saw were detailed and provided a good overview of the patient's particular needs and required interventions. However, it was not clear which members of the team had been involved in the completion of these formulations; some had been completed two years previously and had no review date. It was also unclear if these were live documents. We think it would be beneficial if all patients on Vaara and Ythan Wards had formulations that were dated, with identified goals and targets reflected in person centred care plans.

Care records

Information on patients care and treatment is held on the EMIS system. Some information was difficult to locate, for example the name of the patient's doctor or social work mental health officer (MHO). The daily progress notes regarding patient care and treatment lacked detail, with inconsistent evidence of specific interventions, for example, the provision of one-to-one support. Progress notes showed input from other disciplines, such as psychology and

occupational therapy. Daily progress notes contained information regarding clinical team meetings. We saw that these meetings take place on a regular basis and during each meeting there is an action plan of what is being taken forward to the following meeting. Some MDT meeting records did not note which members of the team had attended the meeting, or their job title. It was not always clear if the patient had been invited to the meeting, if they attended and if not, then why not. There was no record of feedback to the patient after the meeting. We fed this back to the service at our end of day meeting and were advised that this would be taken forward.

Use of mental health and incapacity legislation

Patients on Vaara and Ythan wards are subject to restrictions of medium security and all patients were detained either under the Mental Health Care and Treatment (Scotland) Act 2003 (MHA) or the Criminal Procedure (Scotland) Act 1995 (CPSA).

When a patient is subject to compulsory measures under the Mental Health Act, we would expect to see copies of all legal paperwork in the patient files. Part 16, in sections 235 to 248 of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments.

We found no issues regarding the legal paperwork required to detain patients and all certificates authorising treatment under the Mental Health Act (T2 and T3 certificates) were present. For a small number of patients we found prescribed medication that had not been properly authorised under the Act. We fed this back to the SCN on the day of the visit.

Recommendation 2:
Managers should introduce an audit system ensure that all medication prescribed under the mental health act is authorised appropriately.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (AWI) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of AWI. On reviewing patients file, we found an-out-of-date section 47 certificate. We also found a section 47 treatment plan beside their medication kardex but the accompanying section 47 certificate was held in the electronic system. We raised this with the SCN on the day of our visit.

Rights and restrictions

Vaara and Ythan wards are medium secure units, with locked doors which is proportionate to the needs of the patients. Visiting restrictions have eased since the pandemic, however visits must be pre-arranged and can be accommodated in a visitor's room at the entrance to the wards.

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and they are written when a person has capacity to make decisions on the treatments they want or do not want in the future. Health boards have a responsibility to

promote advance statements. We were pleased to see that many patients had an advance statement and reasons were recorded if a patient chose not to complete an advance statement. We were also pleased to see that this was also reviewed at each CPA meeting.

We were advised that advocacy services are based on-site at the hospital. All of the patients we spoke to were aware of their rights and many of them had involvement from the advocacy service.

When patients require restrictions to be placed on them, section 281-286 of the Mental Health provides the framework for these restrictions to be put in place. All patients in medium secure facilities are automatically 'specified persons' in respect of section 286, which is in relation to safety and security in hospital. For any other restrictions, patients must be individually specified. We found that all restrictions were legally authorised.

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

On our last visit to the wards in 2019, we raised the issue of patients who were experiencing high levels of stress and distress were having to be transferred to the State Hospital. During our visits to Vaara and Ythan wards we were told that patients were, on occasion, made subject to seclusion on the ward. At times they may have to be nursed in the crisis suite which is located in Spey Ward at the Rohallion clinic. The practice of transferring patients to the State Hospital is in place if an individual cannot be safely cared for in the crisis suite. We were told that the plan is to re-design the suite to make it an appropriate environment to nurse patients who are experiencing high levels of stress and distress. NHS Tayside estates are considering plans for this. We look forward to hearing how these developments are progressing.

Activity and occupation

During our visit, we were told that both wards had a standard activity timetable. This included attending the on-site gym, carpet bowls, five-a-side football and short tennis. Patients had the opportunity to cook in the self-catering kitchen, attend the café and play video games in the gaming room on the wards. There was a pool table in both wards and a number of board games that patients can play.

From all of the patients that we spoke with, we heard from them that there was not enough to do on the ward and that they were bored. This issue was particularly difficult for patients who had little or no time out of the hospital grounds. Patients told us that unless they were interested in the limited range of activities on offer, then they had to find their own things to do. Patients told us they would like to do activities that would upskill them and/or lead to future employment e.g. woodworking and education. We heard that the local college used to provide tutors to support patients' education needs but this had stopped following a review of the criteria for engagement.

When reviewing patients' files, we saw little evidence of person-centred activities on offer. There appeared to be an over-reliance on the use of internet access as a form of meaningful

activity. We were of the view that the wards could benefit from a dedicated activity co-ordinator, whose only role would be to source person-centred activities.

Recommendation 3:
Managers should ensure that there are a range of person-centred activities on offer to patients and should give consideration to appointing a dedicated activity co-ordinator.

The physical environment

The layout of the wards consists of single en-suite single rooms. The wards benefits from a number of pleasant outdoor courtyard areas which patients have access to during the day. Both wards had a lounge area, a gaming room and a pool table. The laundry rooms and self-catering kitchens can be accessed by patients throughout the day. There was a medium secure garden which was accessed by steep steps and is surrounded by a high fence.

On the day of our visits, both wards felt calm and were light and airy. Work was underway to make the visitors' rooms more pleasant by re-painting and adding new furniture.

Patients overwhelming complained about their bedrooms. The beds were standard anti-ligature beds with a plastic mattress. We heard that the beds were uncomfortable and the mattresses made the patients feel hot and sweaty. We were told that shower doors were removed and that patients found it undignified using the toilet behind a shower curtain. The rooms also suffered from condensation from the shower and because cupboard doors had been removed, patients complained that their personal belongings became damp. We fed these issues back at our end of day meeting. The service was aware of the issues and are in discussion with infection control regarding an alternative solution to the plastic mattresses.

Recommendation 4:
Managers should urgently review the current beds/mattresses in use on the wards and explore alternative options to plastic mattresses.

Recommendation 5:
Managers should ensure a programme of work to replace shower curtains with anti-ligature bathroom doors and identify timescales for this work.

Any other comments

We heard about the difficulties patients were having opening a bank account especially, if they had no time out of the ward. Without a bank account, patients were unable to do online shopping, which can form part of their ongoing rehabilitation programme.

We heard how challenging the last 18 months had been since the start of the Covid-19 pandemic. Staff had to respond creatively to restrictions on community visits by developing more on-site activities. Gardening groups were set up and vegetables grown which were then used to cook with. To support staff, the senior leadership team created well-being rooms where staff could spend time off the ward. Feedback from staff had been very positive.

Summary of recommendations

Recommendation 1:
Managers should ensure that care plans are person-centred and detail clear interventions and outcomes. They should evidence patient participation, be regularly reviewed and their quality audited.

Recommendation 2:
Managers should introduce an audit system ensure that all medication prescribed under the mental health act is authorised appropriately.

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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
Executive director (nursing)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

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

When we visit:

- We find out whether 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.

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