Mental Welfare Commission for Scotland

Report on announced visit to: Penny Lane and Rose Lane Wards, Midlothian Community Hospital, 70 Eskbank Road, Bonnyrigg, EH22 3ND

Date of visit: 5 July 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.

Penny Lane and Rose Lane Wards provide in-patient care for patients over 65 who require admission for mental health care in Midlothian. Based in Midlothian Community Hospital, the adjoining wards occupy the footprint of the former Rossbank Ward.

Older people's in-patient mental health services in Midlothian have changed in the last two years. Previously, Rossbank was a 24-bedded ward, caring for older adults with functional mental illness and those with dementia who required inpatient assessment. Next to this, Glenlee Ward provided 20 beds for patients with dementia and complex needs who required hospital-based complex clinical care (HBCCC). A substantial number of patients who were admitted to these wards were from East Lothian and were receiving care in Midlothian due to a lack of in-patient facilities in their local area. It was planned that this would change with the opening of a new in-patient ward in East Lothian in 2020.

When the Commission last visited Midlothian Community Hospital in 2019, we were advised of plans to close Glenlee Ward and re-develop Rossbank Ward, dividing it into two smaller units. These were to provide care for patients with the same needs that both wards previously offered. The new wards opened early in 2020, just at the start of the Covid-19 pandemic.

Penny Lane is a twelve-bedded, mixed-sex ward providing care for patients with dementia who require either in-patient assessment, or longer term HBCCC care. Rose Lane, an adjoining annexe, is an eight-bedded mixed-sex ward caring for patients with functional mental illness.

This was the first time we had visited since the redevelopment of the in-patient service. The Commission last visited Rossbank Ward in June 2019, as part of our themed visit looking at older people's functional mental health in hospitals**.** On the day of this visit we wanted to see hear from patients, carers and staff about their experiences and to view the new ward environments.

Who we met with

We met with, and reviewed the care of six patients. We also met with/received feedback from five relatives.

We spoke with the service manager, the senior charge nurse and lead nurse on both wards. In addition we met with the advance nurse practitioner and activity co-ordinator.

Commission visitors

Juliet Brock, medical officer

Gillian Gibson, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

The feedback we received from patients and carers from both wards was generally very positive. Patients who were able to tell us about their experiences described nursing staff as supportive and caring and we observed warm interactions between staff and patients on both wards on the day of the visit.

Comments from relatives included that staff were "excellent", "friendly, helpful and kind". One relative, whose family member had been an in-patient in Penny Lane ward for several months, wrote to us saying "I cannot praise the doctors and nurses enough for what they have been doing [for my relative]".

Relatives reported variable experiences of communication from the clinical team about their relative's care. One person described the communication and support from the staff as "excellent", whilst another carer had not had such a positive experience and said they had not seen a doctor or been involved in discharge planning. Another relative commented that they received limited feedback from staff unless they sought this out. One family member told us they felt welcomed from the point of the arriving in reception, although they did also say that nurses on duty on the ward gave them feedback about their family member, but they had not been involved in recent meetings and would have welcomed "more structured communication".

We heard that feedback forms were available for visitors to complete and that feedback was welcomed by the team to continue to improve the service. We were told by senior staff that feedback forms were complimentary, with relatives consistently emphasising the kindness and compassion of staff.

We were pleased to note that information leaflets, designed for patients and their carers, had been developed by both wards. The leaflets provided an introduction to the staff team and ward regime, outlined visiting arrangements and provided information about advocacy services and carer support. The leaflets encouraged feedback about individual experiences through feedback forms and via the patient experience team.

Recommendation 1:
Managers should consider how both wards can optimise communication with families, to ensure they consistently receive updates about their relative's progress and have the opportunity to participate in discussions about their care, treatment and future planning.

Multidisciplinary team (MDT)

The multidisciplinary team consisted of nursing staff and a consultant psychiatrist, supported by other medical staff, in addition to input from occupational therapy (OT) and activity co-ordinators. Input from physiotherapy, speech and language therapy and dietetics could be arranged by referral on an individual patient basis when required.

We heard there had been a reduction in OT support, with OT staff consequently no longer being able to join weekly MDT meetings. The ward staff said this had an impact on the team.

On both wards there was weekly MDT meeting that professionals from community services were also able to join where appropriate for individual patients (including remotely). A clinical pharmacist also attended the weekly MDT meeting. Ward staff also had a 'rapid run-down' meeting with the consultant psychiatrist every Friday.

We were advised that both wards were experiencing significant staffing challenges, with agency and bank staff often required to support shifts, with shortages in permanent staff due to a combination of high sickness levels, as well as difficulties with staff recruitment and with retention. This situation, while not unique to Midlothian, continues to be experienced by mental health services across Scotland, with a national shortage of nursing staff having significant impact. With no other mental health wards based on the hospital site, we were told that the relative isolation of the wards in Midlothian (as compared with the larger and more central hospitals in NHS Lothian), posed an added challenge for the team, particularly when staff were required urgently. We were advised that staffing concerns had been escalated to senior managers in NHS Lothian.

With regard to medical cover, emergency cover was available during the weekend from junior staff on an out-of-hours rota, with support from an on-call consultant psychiatrist, if required.

In spite of the challenges the team described, we heard of positive staffing initiatives. This included the recent addition of nurse assistant practitioner posts to the team, with a focus on leadership and organisation. An advanced nurse practitioner (ANP) post had also been introduced to the team. We were told this had been hugely positive, the ANP being described as a "brilliant addition", particularly due to their additional expertise in physical health, which was described as enhancing MDT discussions and liaison with medical wards and the hospital at home team.

We also asked about training. It was concerning to hear that none of the nursing staff in the wards had received stress and distress training. We were told this was largely due to training being curtailed during the pandemic. We were advised that managers were liaising with a dementia nurse consultant to facilitate this training. We discussed with senior staff on the day that stress and distress training for staff should be a priority, particularly in Penny Lane.

There was no psychology input to the wards at the time of this visit. We were informed of future plans for in-patient psychology on both wards, but funding was yet to be agreed for this. We heard from the staff team that the lack of psychology input had a significant impact on the care provision. When visiting other older people's dementia wards in NHS Lothian, we have heard that the addition of psychology input has been invaluable, particularly in supporting staff to develop individual formulations and behavioural support plans for patients, as well as providing/supporting stress and distress training for staff.

Recommendation 2:
Managers should prioritise the provision of clinical psychology support to both wards.

Care records
Care records were mainly held on the electronic patient record system TRAKcare. In the records we examined, we found that entries in the daily care records were generally of a good

standard, with some making reference to individual participation in activities. The recording of MDT meetings was also clear.

Nursing care plans were of mixed quality. We found some good examples of person-centred care planning, with regular reviews, including some stress and distress care plans.

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

Use of mental health and incapacity legislation

We found that patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') had medical treatment properly authorised.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed.

In the patient files we reviewed, copies of documents pertaining to the Mental Health Act were in place. The same was found regarding documentation relating to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), with copies of power of attorney or welfare guardianship certificates available, where patients had welfare proxies in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Section 47 Certificates should be accompanied by an individual treatment plan for the patient. We found section 47 certificates in place for many patients and a number of these included detailed treatment plans, however in a few cases we could find no treatment plan present.

For patients who had covert medication in place, appropriate documentation was in order. The Commission has produced good practice guidance on the use of covert medication at:
https://www.mwcscot.org.uk/node/492

Recommendation 3:
Medical staff must ensure that patients who lack capacity to consent to medical treatment have a section 47 certificate in place and that this is accompanied by an individual treatment plan.

Rights and restrictions

The wards operated a locked door, commensurate with the level of risk identified with the patient group.

We were pleased to note that the information leaflets provided for patients/families provided information about advocacy support, including the name and contact details of the worker providing this support for each ward.

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

Both wards had activity co-ordinators and OT support. We heard that the activity co-ordinator on Rose Lane ward had been in post for a year and regularly engaged in one-to-one sessions with patients, tailoring activities to their individual interests. We saw clear evidence of this in the case files, with individual patients being involved in a range of activities. Feedback from relatives was also positive in this regard and we heard examples of the OT liaising with relatives in individual cases. Concern was shared with us that patients on Penny Lane Ward had lacked some stimulation. There had only been a recent appointment to the activity co-ordinator role and we heard from staff that the activity coordinator was sometimes "pulled into" doing other tasks on the ward when staffing was short. The activity timetable on Penny Lane ward was blank on the day of our visit. We discussed these concerns with senior staff on the visit and were assured of plans to develop the activity programme on Penny Lane ward with the new member of staff in post.

The physical environment

Penny Lane Ward was accessed directly from the main hospital corridor. In contrast, Rose Lane was only accessible through Penny Lane, via security doors at the end of ward. We heard from some family members that walking through the communal area in Penny Lane to visit a relative in Rose Lane ward could feel upsetting at times. The staff recognised that this situation was far from ideal. We were advised that plans to create a new entrance for Rose Lane, accessed directly from the grounds of the hospital, had been delayed. However funding was in place and the works were awaited.

Penny Lane Ward

The main communal area consisted of a large bright open plan lounge/dining area, opening onto a private courtyard garden. Additional, smaller communal spaces around the ward included a quiet room, a Snoezelen multisensory room and a room the OTs used with patients for cognitive stimulation therapy. The Snoezelen room was equipped with sensory equipment, although appeared cluttered and was partly used for general storage. It was reported by staff to be well used and one carer also commented that their relative had used this and it was "a great facility to have". Overall, the communal environment in Penny Lane appeared rather bare, with limited artworks or objects of interest on the walls and around the corridors. The décor also looked somewhat shabby, with paintwork appearing to need a refresh. We thought that dementia friendly signage around the ward could also have been improved.

Staff also highlighted a problem with noise, due to acoustics on the ward that accentuated everyday sounds (such as scraping of chairs, sounds of trolleys). We noticed this on our visit and a few of the patients who were able to communicate with us also referred to the

environment being noisy. Staff told us that this could add to patients' distress, particularly at busy times of day, like mealtimes. The service manager explained that there had been a problem with re-installing sound absorbing panels.

We were advised that the above environmental issues had all been identified and that the ward was awaiting improvement work, including complete refurbishment of the main area. A grant from the NHS Lothian charity had also been acquired to fund the instalment of specialist dementia doors and vinyl wall coverings.

There were 12 en-suite bedrooms on the ward, including two anti-ligature rooms, for patients deemed to be at high risk. Patients were able to personalise their rooms.

The secured garden had lots of seating, offered sheltered spaces and areas of interest, such as raised beds. Access to the garden was mainly locked during the day, with patients requiring supervision to access the space. Staff explained that this was due to safety issues; the paving surface and corners of some of the built elements were not dementia friendly.

Rose Lane Ward

The Rose Lane annexe had a much smaller footprint. In addition to the eight en-suite bedrooms, there were two main communal areas on the ward, occupying large rooms that had formerly been patient dormitories. These rooms had not yet been refurbished and it was evident the staff team were making the best use of the spaces on a temporary basis.

The main communal space used by patients was a multifunctional lounge/ dining / activity area. It was full and very lively on the day of our visit. Although somewhat makeshift in appearance, much effort had clearly been put into making the space as inviting as possible, with comfortable furniture, an array of wall decoration and items of interest and shelving units full of books, activities and art and craft items. None of the patients we spoke with raised issues about the environment.

The second communal area was subdivided by temporary screens. This also had multifunctional use as a group space, a meeting space, a quiet space and a place for one to one work.

There was no garden area on Rose Lane Ward. The only outside space available on the ward for patients, was to access the garden on Penny Lane. This required the accompaniment of staff, to exit the locked door and support the patient whilst in the Penny Lane environment. The hospital also has a community garden in the grounds, run by the Cyrenians charity. Staff told us that patients who able to leave the ward on pass, often enjoyed visiting this space with relatives.

Original plans for the redevelopment of Rose Lane had been stalled by the Covid-19 pandemic. However, we were pleased to hear of the planned re-design of the communal spaces on the ward, which included installing doors to access a new secure outdoor area, exclusively for Rose Lane patients, as well as adding the new external ward entrance.

In relation to all the environmental works awaited across the wards, the service manager advised us that due to complex private finance initiative and legal issues, the process had been prolonged. However, this was being addressed by senior managers in NHS Lothian,

revised plans and quotes had been obtained, funding had been agreed and contracts for the work were awaited.

Any other comments

Delayed discharges

We heard that two patients were awaiting a nursing home placement and that their discharge was delayed due to a lack of available places. Senior staff told us there was a good relationship with the discharge team based in the hospital and that delayed discharges were constantly under review by the flow hub. There was a waiting list for admission to Penny Lane ward, but not to Rose Lane. We were told there was good support from the Midlothian older adult community mental health team.

Summary of recommendations

Recommendation 1:
Managers should consider how both wards can optimise communication with families, to ensure they consistently receive updates about their relative's progress and have the opportunity to participate in discussions about their care, treatment and future planning.

Recommendation 2:
Managers should prioritise the provision of clinical psychology support to both wards.

Recommendation 3:
Medical staff must ensure that patients who lack capacity to consent to medical treatment have a section 47 certificate in place and that this is accompanied by an individual treatment plan.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving 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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