Mental Welfare Commission for Scotland

Report on unannounced visit to:

Esk Ward, Rohallion Secure Care Centre, Muirhall Road, Perth PH2 7BH

Date of visit: 28 February 2023

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 and medium secure services based at Murray Royal Hospital, Perth. It provides forensic care for patients from the North of Scotland. Esk Ward is a 12-bedded low secure assessment and recovery ward. On the day of our visit the ward had seven patients. We last visited this service on 10 July 2019 and made no recommendations on that visit.

For this visit, we wanted to hear how patients, staff and relatives have managed throughout the Covid-19 pandemic and look, in general, at the care and treatment being provided to patients on the ward.

Who we met with

We met with and reviewed the care and treatment of five patients and spoke with one relative.

We spoke with the senior charge nurse (SCN), consultant psychiatrist and the head of nursing at a feedback meeting following the visit.

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 ward. They were described as “bubbly” “friendly” and “kind” with “great personalities”, and involved patients in decisions about their care and treatment. Patients told us they felt safe in the ward and could approach staff with any concerns they had, however they told us they regarded the food as “adequate”.

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, 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 care plan audits had commenced the previous month and were overseen by a practice development nurse and supported by other nurses as part of Tayside Quality Improvement Plan (TQuIP). On-going work will take place which will focus on developing a care plan training package.

During our visit, we reviewed patient’s care plans on the electronic patient record system, EMIS. The care plans we saw appeared to be split into an initial care plan and a review document. While the care plans appeared person-centred, the review document was difficult to read and could be improved upon if they were amalgamated into one document, as is the practice in other mental health in-patient wards in Tayside. Care plans would benefit from having detailed summative reviews that outlined nursing interventions and patients’ progress in meeting specific goals. There were a number of separate care plans on file and it was difficult to get a sense of the individual, their background, needs, outcomes and interventions that were required for patients to make progress towards their goals. Some plans that were described as care plans were in fact risk assessments/management plans. We found inconsistent evidence of patient involvement in their own care planning with some patients telling us that they did not have a copy of their care plan.

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. We were pleased to see CPA used on the ward for some patients and found the information contained in this document to be accessible, detailed and containing clear evidence of patient participation.

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 Esk Ward. This included nursing staff, psychiatrists, psychology, dietetics, occupational therapy (OT), social work and allied health professional staff. There was no on-site pharmacist; pharmacy input was provided from Murray Royal Hospital. Psychology input was on an individual referral basis.

We were told that the ward was funded for 10 band 5 registered mental health nurses (RMNs) however it should be funded for 11.8 registered staff. On the day of our visit there were four whole time equivalent band 5 vacancies. The ward used bank staff to provide a level of continuity for patients. It was also investing in student nurses and making Esk Ward a place that students chose to work after qualification. The issue of staff shortages was raised on the day of our visit by patients and relatives. We were told that staff shortages had led to patients being unable to attend therapeutic activities.

We heard from staff that the remit of the ward can appear unclear, with them being unsure if is it an acute ward or a rehabilitation ward. This uncertainty can be challenging for staff. However, on the day of our visit we spoke to members of nursing staff who spoke positively about working on Esk Ward and the strong team ethos.

Care records

Information on patients' care and treatment was 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 and tended to be descriptive, for example describing the patient as being settled or visible. The notes did not appear to be person-centred and times used pejorative language, for example describing the patient as sullen and irritable. There was inconsistent evidence of specific interventions informed by the patient's care plan.

Recommendation 2:
Managers should ensure continuation notes are regularly audited to ensure they are person-centred and that entries made by nursing staff meet the Nursing and Midwifery Council (NMC) professional standards.

Progress notes showed input from other disciplines, such as psychology. Daily progress notes contained information regarding MDT clinical team meetings. We heard that clinical team meetings were held every two weeks on the ward and involved a number of professionals such as psychology, OT, social work and advocacy. We saw evidence of patients being invited to clinical meetings. The MDT clinical team meetings were recorded using a pro-forma. At times, this was comprehensively completed and documented discussions that took place at the meeting were clearly indicated, with defined plans of action to follow. However we also found details were missing, for example those who were present at the meeting and their job title.

We found MDT risk assessments in place however there was no accompanying risk management plan or opportunities documented for positive risk taking.

Use of mental health and incapacity legislation

On the day of our visit, patients on Esk Ward were detained either under the Mental Health Care and Treatment (Scotland) Act 2003 (Mental Health Act) 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 of the Mental Health Act, sections 235 to 248 set 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 on file. Where an individual lacks capacity in relation to decisions about treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act (2000) legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. Section 47 treatment certificates had been completed and assessed as appropriate. We would however suggest that section 47 certificates are filed with the drug prescription sheet, alongside T3 certificates.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

In the case files that we reviewed, we saw copies of power of attorney/guardianship certificates with the accompanying powers.

Rights and restrictions

Esk Ward is a low secure unit, with locked doors which was proportionate to the needs of the patients. Visiting restrictions had eased since the pandemic, however visits had to be pre-arranged and could be accommodated in a visitor's room at the entrance to the ward.

When we are reviewing patients' 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 some patients in Esk Ward had an advance statement. However if a patient chose not to complete an advance statement we would like to see the reason recorded.

We were advised that advocacy services are based on-site at the hospital. Most of the patients we spoke to were aware of their rights and many of them had involvement from the advocacy service. We also saw evidence of advocacy involvement for a number of patients in their files.

However, one patient we spoke to was not aware that they were detained. We would like to see patients' rights being explained to them and this being revisited and documented by nursing staff when a patient has the capacity to engage in such a conversation at the appropriate stage of their illness and recovery.

When detained patients require restrictions to be placed on them, section 281 to 286 of the Mental Health Act provides the framework for these restrictions to be put in place. Where a patient is a specified person, the Commission would expect restrictions to be legally authorised and that the need for specific restrictions are regularly reviewed. On the day of our visit, six patients were specified for safety and security. We found that all restrictions were legally authorised however we were unable to find a reasoned opinion as to why restrictions were put in place. We were advised at our feedback meeting that all specified patients have a reasoned opinion filed in a part of the system that we had not accessed during our visit. We were satisfied with this explanation.

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

During our visit, we saw that the ward had an activity timetable on the wall. Activities included attending the on-site gym, healthy cooking, attending the allotment, walking groups, carpet bowls and accessing internet sessions. Unfortunately this timetable was out-of-date.

Patients had the opportunity to cook in the self-catering kitchen however, at the time of our visit the self-catering kitchen had to be locked. We heard from one patient, who had progressed from medium to low secure, that they found it difficult not having open access to the self-catering kitchen. In their view this was more restrictive than when they had been on a medium secure ward.

Patients on Esk Ward were able to access the day rooms which were quiet areas where they could play video games. There was also a pool table on the ward and a room to watch television. Perth College have a presence on the ward providing educational activities for patients.

All of the patients we spoke with told us that there was not enough to do on the ward and that they were bored. They reported activities as non-existent, apart from access to the internet. Although we did see good evidence of OT involvement in patients' notes, overall there was inconsistent evidence of activities on offer. At our feedback meeting, we were advised that all patients have a personalised activity planner.

We were advised that one of the nurses on the ward had the responsibility to arrange activities. However, we were of the view that the ward 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 Esk Ward consists of single en-suite rooms. The ward benefits from two small outdoor courtyard areas which patients have access to during the day. However, patients and staff told us that the lack of a low secure garden is an issue.

The ward had a lounge and dining area, two day rooms and a pool table. The laundry rooms and self-catering kitchens were locked but could be accessed, on request, by patients throughout the day.

On the day of our visits, the ward felt relatively calm, bright and airy.

Any other comments

We heard that there were two patients on Esk Ward whose discharges from hospital were delayed. One patient had been delayed for more than two years. These delays were due to housing and support requirements. The Commission is of the view that discharge planning should begin as early as possible after admission to prevent patients having to remain unnecessarily in hospital.

We heard how challenging the last three years had been since the start of the Covid-19 pandemic. However we heard that the team had pulled together and tried to create a culture in the ward whereby the patient remained at the centre. Daily checks were introduced for staff and peer-to-peer support was encouraged. The ward introduced 'Greatix' where good work could be recorded and celebrated. 'Excellent Esk' was also introduced – the ability to nominate another member of staff for a piece of good practice, however small. 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 ensure continuation notes are regularly audited to ensure they are person-centred and that entries made by nursing staff meet the Nursing and Midwifery Council (NMC) professional standards.

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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.

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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