Mental Welfare Commission for Scotland

Report on announced visit to: Ellen's Glen House, Thistle Ward, 72 Carnbee Avenue, Edinburgh, EH16 6FF

Date of visit: 20 November 2023

Where we visited

Ellen's Glen House is a community hospital in Edinburgh. The hospital houses two units, Thistle ward and Hawthorn ward. Hawthorn provides care for older adults with complex physical health needs who require respite or longer-term inpatient care.

Thistle ward provides hospital based complex clinical care (HBCCC) for older people with severe and enduring functional mental illness. It was designed as a 30-bedded ward but had been run as a 27-bedded unit in recent years.

Thistle ward occupies the ground floor of Ellen's Glen House. The building is owned and managed by Walker Healthcare although healthcare and hospital services, such as catering, cleaning and laundry, are managed by Sodexo. The building manager and hotel services manager are based on site.

We last visited this service in August 2019 and made no recommendations. At that time, we were told that the remit of the service was gradually changing, with the inpatient group generally being younger and more physically able than in the past, with patients under the age of 65 being referred. Some individuals were being referred to the service for long term rehabilitation, rather than continuing hospital inpatient care, and a number had recently been successfully discharged home with community care packages, rather than to a care home, which had previously been the main pathway for ongoing care.

At the time of this visit we were told that there had been a recent high throughput on the ward, with nine people being discharged (seven of whom had been discharged to care homes, with two having returned home with support). The unit had a very large population for the nature of the service and was at capacity with 27 patients.

On the day of this visit we wanted to meet with individuals and carers and to hear about their experiences of care.

Who we met with

We met with and reviewed the care of six people and spoke with two relatives.

We met with the service manager and the acting senior charge nurse. A significant number of ward staff also asked to speak with us in person to talk about their recent experiences working in the service.

Commission visitors

Juliet Brock, medical officer

Kathleen Liddell, social work officer

Margaret White, senior trainee in psychiatry

What people told us and what we found

Care, treatment, support and participation

From the outset we were made aware by the service manager and acting senior charge nurse (SCN) that the service had been experiencing challenges for some time, with the last two years reported as being a period of significant “upheaval”.

We were told that repeated changes in senior nursing leadership on the ward had been a significant factor. Additionally, several experienced staff had left, with subsequent difficulties in recruiting to posts. A new acting SCN had been brought in from another HBCCC service to support the team, just days prior to our visit.

We noted that bed numbers had not been reduced, despite these staffing challenges. The two other (30-bedded) mental health HBCCC units in Edinburgh had had their bed numbers capped for some time (at 21 and 19) due to staffing shortages.

This background provided an important context in which to understand the feedback we received from individuals, their families/carers and from the staff who asked to speak with us during the visit.

We received mixed feedback from the individuals and families/carers whom we spoke with. Two individuals and one carer gave positive feedback about their experience and the support they received from staff, with one relative telling us “I can’t praise the team here enough, they’re so caring and they look after my mum”.

Concerns were however raised about some changes to the ward, including the number of staff who had recently left (particularly on nightshift), and certain “rules” that had been put in place by senior staff (including a ban on vaping and eating meals in bedrooms), which were felt to be unfair. Some individuals commented that they found the number of unfamiliar staff (banks and agency) difficult. Both relatives we spoke with expressed concern about staffing levels and the impact this had on care and activity provision.

Several individuals spoke negatively about their experiences on the ward. As well as reporting restrictive practices and questioning the attitude of some staff (two people for example complained to us that staff openly “gossiped” on the ward), individuals told us there was a lack of things to do and several complained that the ward was loud at night. People also told us they had little involvement in their care planning and limited opportunity to participate in their care meetings.

The staff who asked to speak with us consistently spoke about providing person-centred care to people on the unit; “we’ve always been a very person-centred ward”. One staff member, who had been with the service for over a decade, spoke of the service winning awards when they joined, but in contrast remarked about the current way of working telling us that “it is set up to fail”, adding “we are failing patients

because we are only providing essential care". Concerns were raised about staffing levels, and we were told that most shifts had four staff, as compared to six in the past. Many staff who asked to meet with us spoke of recent difficulties for the team and of low morale.

Recommendation 1:
Managers should consider whether the unit is adequately staffed to provide safe and effective care and treatment for the number of individuals on the ward and whether a cap to reduce bed numbers is required. This is particularly important given the high proportion of detained patients on the ward and the duty to provide care in accordance with the principle of reciprocity under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Prior to the visit we had spoken with a member of staff who raised concerns about nursing practices and culture in the staff team. Examples included medication errors and behaviours of some staff (such as sleeping on nightshift). A "toxic and bullying environment" was described, with some staff reported as unwilling to work towards improving standards of care.

Amid these contrasting accounts, what did appear evident was that in the absence of consistent, supportive leadership, a negative culture had developed over the previous two years, resulting in low staff morale and impacting on the experiences of individuals receiving care and their families.

Although we are aware that since our visit a new SCN has been permanently recruited, which is a positive development in providing continuity and leadership to the team, we would urge managers to consider the potential benefits of additional expertise to address the range of staff concerns raised on the visit.

Multidisciplinary team (MDT)
The MDT consisted of nursing staff and a consultant psychiatrist, who visited weekly. A full-time activity co-ordinator provided input five days a week and there was regular input from music therapy.

We were told that staff recruitment had been extremely challenging; it was thought this partly related to being on an isolated site. At the time of this visit there was a vacancy rate for registered nurses of over 50% in the service. We heard that some bank staff, including retired staff, worked exclusively on the unit and provided a good level of continuity, but that there was also regular use of agency staff, particularly at night. Although recruitment and retention had been difficult, we heard that three quarters of the team had been in post in the unit for over six years.

On our last visit there was occupational therapy (OT) input to the ward. On this visit, OT was available by referral only, with no representation directly to the MDT. We were told that there was a lack of resources to support a recovery focus, with

physiotherapy, speech and language therapy and psychology also not a routine part of treatment and available by referral only. Whilst the removal of OT input in the MDT was consistent with changes in provision, we had seen on recent visits to the two other HBCCC units in Edinburgh (which provide dementia care), both those units did have dedicated psychology input to their ward. Since this visit we have been advised that the gap in psychology provision has been highlighted to managers for some time and that there are now plans underway for significant service reconfiguration over the next six months which it is hoped will enable access to psychology.

Recommendation 2:
Managers should review the needs of the individuals in the ward and consider whether the current MDT meets those needs and whether additional input from allied health professionals (such as OT) is indicated.

We were told that there was weekly input to the ward from dietetics and physiotherapy and that medical input was available during the week to provide physical health reviews when required. Advanced nurse practitioners (ANPs) were also available for additional physical health support.

MDT meetings took place weekly when the consultant attended. These meetings involved a 'rapid run-down' format providing a brief discussion of all individuals, with more detailed three-monthly reviews, involving carers, carried out for a few individuals each week.

According to staff, referrals to social work were usually made towards the end of admission, when an individual was ready to be discharged to the community. This was in contrast to the approach in many other units, where social work was involved at an early stage, helping to reduce the delays that often occurred when trying to find care home placements or community packages of care.

Recommendation 3:
The MDT should review the timing of referrals to social work and consider whether earlier involvement of social work colleagues would improve pathways of care for individuals.

Care records
Care records were stored electronically on TRAK, the electronic patient management system used by NHS Lothian.

In the notes we viewed, we consistently found daily recording to be basic and of a poor quality. There was little focus on using a strengths-based approach to care and the language used by staff in the written record was sometimes negative and judgemental. Canned text (where pre-populated headings were available to guide the documentation of aspects of care) was not being used. The nursing records made little reference to care plans, individual progress or working towards care goals.

In contrast, notes of activity participation recorded by the music therapist were highly detailed and personalised, focussing on individual strengths and ongoing support required.

We saw no records of one-to-one discussions between individuals and nursing staff in the records we viewed and limited evidence of reviews by the consultant psychiatrist. Records of the MDT meeting were not always apparent; in some clinical files we could find no record of MDT meetings for several months. Where we did see these, they were of mixed quality.

We highlighted these concerns with the senior manager on the day of the visit. We were told that the weekly meeting with the consultant involved a 'run down' of all patients, but this was not usually documented in individual records and only three-monthly individual reviews were documented in detail.

Documentation of three-monthly clinical reviews were held separately on a shared drive and were not easily accessible. In some individual records we could find no evidence of these review meetings being recorded for six months.

Recommendation 4:
Managers should undertake a significant review of care records and develop an improvement programme to drive up standards in record keeping, including daily records, one-to-one discussions and medical reviews. Consideration should be given to how and where clinical reviews are recorded, so that these can be clearly evidenced and form part of individual care records.

Since this visit we have been advised that a number of changes have already been made in relation to this recommendation, including a system whereby all patients are seen at least monthly by the consultant, with this recorded in individual clinical notes. We welcome the improvement work already underway and look forward to seeing this and further progress when we next visit.

Although we found evidence of some detailed risk assessments, we saw examples where these had not been updated; in one case it had been over three years, despite more recent incidents involving the individual having taken place.

Recommendation 5:
Managers should undertake an audit of risk assessments and instigate a programme of improvement work to ensure risk assessments are regularly reviewed and updated where required for all individuals.

We did find good evidence of physical health reviews, with specialist referrals where appropriate. We did not see a clear process for routine annual reviews for patients who were in hospital for a prolonged period. We expected this to be in place in long-stay wards to ensure that routine health screening, which would normally be offered

in the community by GPs, was undertaken. We were told by senior staff that this had been discussed at a recent quality improvement meeting and there were plans to introduce routine health screening.

The nursing care plans we viewed varied considerably in quality. In some cases, we saw no evidence of care plans being reviewed for several years. We found no care plans focusing on activities, with the exception of music therapy.

The Commission has published a good practice guide on care plans[1]. 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.

Use of mental health and incapacity legislation

On the day of the visit, 17 people were detained under the Mental Health Act.

We were able to find documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), where appropriate.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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.

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.

We looked at the prescribing for individuals, which was recorded on a traditional paper Kardex format and viewed the section 47 certificates in place (the widely used electronic prescribing system HEPMA had not yet been introduced on the ward). We found that no certificates had been recently completed and many had expired. We raised this with senior staff on the end of the visit as a matter that required urgent review by the medical team. We have since been informed by the consultant psychiatrist that all section 47 certificates were reviewed prior to the Commission's visit and that all were up to date and filed in the nursing office. It is vital that all the clinical team are aware of where these legal records are kept, as it is everyone's responsibility to ensure that treatment prescribed and dispensed to individuals who lack the capacity to consent to this is properly authorised.

[1] Person centred care plans good practice guide: https://www.mwcscot.org.uk/node/1203

The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the Adults with Incapacity Act and an eLearning module has recently been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions.

A number of individuals were receiving covert medication and although we found covert medications pathways in place, some had not been updated or reviewed since they were first put in place. The Commission has produced good practice guidance on the use of covert medication[2].

Recommendation 6:
The MDT should ensure that those receiving covert medication have an up-to-date covert medication pathway in place, which is regularly reviewed.

Rights and restrictions

We heard that independent advocacy support was provided by Advocard. When we spoke with individuals about their rights, there was some awareness of rights and accessing independent advocacy; a few people spoke of having contact with Advocard.

When we asked individuals about issues they might wish to raise with the service or improvements they would like to see, several people spoke about the quality of food provided on the ward and improvements they would like to be made. However, people talked of having a fear of speaking up. There was no patient forum or other setting in which people could provide collective feedback or make suggestions for change. Staff told us that patients were able to give feedback informally on an individual basis if they wished, however this did not address the concerns raised by patients. We raised this with senior staff at the end of the visit.

The family members we spoke with told us that the felt they had limited involvement in the care decisions of their relative. There was also limited evidence of carer support. Again, amongst carers there appeared to be some concern about speaking out about any issues in case this negatively impacted the care of their loved one.

Recommendation 7:
Managers should consider how opportunities for both individuals and carers to provide feedback about their experiences can be introduced. Consideration should be given to creating a forum for individuals on the ward and of providing anonymous means of feedback (such as a box for feedback forms from individuals and carers). Opportunities for carer support and / or information and signposting to local services for carers should also be reviewed.

[2] Covert medication good practice guide: https://www.mwcscot.org.uk/node/492

The Commission has developed *Rights in Mind.*[3] 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.

Activity and occupation

At the time of our visit the activity co-ordinator had been on leave for a period. We heard that a second activity co-ordinator post had been advertised but there had been no applicants.

There was no activity timetable, either for the ward or for individuals. We were told that activities were usually decided on the day, tailored to the group and their preferences. The activity co-ordinator would normally meet with individuals to identify activities of interest to them, including facilitating outings and shopping trips for those able to have passes.

When we spoke to ward staff about activities, we were told that staffing challenges meant that only basic care was provided and there were not sufficient numbers of staff to support activities.

This mirrored what we were told by the individuals we spoke with and there was an acute awareness of the staffing challenges that had an impact on activity provision. One person remarked that they would have liked staff support at times to go to new places in the community, but that this was "never offered" so they had stopped asking.

Music therapy appeared to be the only consistent therapeutic activity on offer, and we heard positive feedback about this from both individuals and carers.

It was disappointing that the range of activities, groups and outings that were on offer during our last visit were not in evidence for this one. With the exception of music therapy, there appeared to be limited opportunities for individuals to engage in meaningful occupation on the ward at the time of this visit.

Recommendation 8:
Managers should review the opportunities for meaningful activity and occupation on the ward and the provision of this when there are staffing challenges.

The physical environment

The ward environment was clean and freshly painted. The large dining room, overlooking the rear garden, provided space for group activities, as well as communal mealtimes.

[3] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

The design of the unit continued to present some challenges. The main reception area for Ellen's Glen House, and therefore the stair and lift access for staff and visitors to Hawthorn ward upstairs, remains in Thistle ward itself, thus providing little privacy for individuals who chose to sit or wander around the reception area.

Thistle ward was designed for up to 30 individuals, with 27 en-suite bedrooms, each with washbasin and toilet, arranged across three corridors. Each corridor had nine bedrooms, with shared shower and bathing facilities and a sitting room. One bedroom in each corridor was designed as a twin room but was used for single occupancy. Individuals were encouraged to personalise their bedrooms, and we saw evidence of this.

Where possible, the corridors continued to be maintained as single sex, with two allocated for females. The sitting rooms offered a range of different spaces to relax. The sitting room in the male corridor had previously been decorated as a bar, housing tables, a fruit machine, TV, keyboard and jukebox, with the male individuals in the unit being involved in this project. Since our last visit this space had been changed and was now a TV lounge.

The garden continued to be a beautifully maintained and well used area, providing an inviting space for both individuals and their families to spend time outdoors. There was a clear pathway through the interconnected garden spaces, enabling people to safely wander through the outdoor environment, which housed sheltered seating areas, a gazebo and features of interest including areas of planting and bird feeders. We heard that there were no restrictions to people accessing this space. Individuals were allowed to smoke in this space, and we noted cigarette stubs scattered under the seating area. This was the only aspect which required to be addressed, especially in light of the Scottish Government ban on smoking within 15 metres from a hospital building.

Summary of recommendations

Recommendation 1:
Managers should consider whether the unit is adequately staffed to provide safe and effective care and treatment for the number of individuals on the ward and whether a cap to reduce bed numbers is required. This is particularly important given the high proportion of detained patients on the ward and the duty to provide care in accordance with the principle of reciprocity under the Mental Health Act.

Recommendation 2:
Managers should review the needs of the individuals in the ward and consider whether the current MDT meets those needs and whether additional input from allied health professionals (such as OT) is indicated.

Recommendation 3:
The MDT should review the timing of referrals to social work and consider whether earlier involvement of social work colleagues would improve pathways of care for individuals.

Recommendation 4:
Managers should undertake a significant review of care records and develop an improvement programme to drive up standards in record keeping, including daily records, one-to-one discussions and medical reviews. Consideration should be given to how and where clinical reviews are recorded, so that these can be clearly evidenced and form part of individual care records.

Recommendation 5:
Managers should undertake an audit of risk assessments and instigate a programme of improvement work to ensure risk assessments are regularly reviewed and updated where required, for all individuals.

Recommendation 6:
The MDT should ensure that those receiving covert medication have an up-to-date covert medication pathway in place, which is regularly reviewed.

Recommendation 7:
Managers should consider how opportunities for both individuals and carers to provide feedback about their experiences can be introduced. Consideration should be given to creating a patients' forum on the ward and of providing anonymous means of feedback (such as a box for feedback forms from individuals and carers). Opportunities for carer support and / or information and signposting to local services for carers should also be reviewed.

Recommendation 8:
Managers should review the opportunities for meaningful activity and occupation on the ward and the provision of this when there are staffing challenges.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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.

Contact details

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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

Mental Welfare Commission 2024