



MENTAL WELFARE COMMISSION  
FOR SCOTLAND

# ‘Greater Expectations’

Report of unannounced visits to continuing-care facilities  
for people with severe and enduring mental illness in  
Scotland in January 2003



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# GREATER EXPECTATIONS

**In January 2003 we visited 18 wards or units in Scotland that provide continuing care to over 350 people. These units provide care to people with severe and enduring mental illness. For people who are likely to be in hospital for a long time these facilities should be homely and should encourage activity, as well as providing skilled therapeutic treatments. While we found some evidence of good and creative approaches to care, our overall impression was of the dullness of life for people living in continuing-care settings. We were concerned about:**

- **the apparent low level of therapeutic, rehabilitative and recreational activities;**
- **the drabness of many of the wards and units we visited; and**
- **how little patients know about their treatment.**

**While we recognise the challenges to staff in providing care in often inappropriate environments, we believe that service providers, managers and clinical staff should have 'greater expectations' of what can be done in providing high-quality care to people with severe and enduring mental illness.**

# I. WHY DID WE CARRY OUT THESE VISITS?

Over the past years the move to community-based mental-health care has brought about a reduction in the number of people living in hospital in Scotland. Bed numbers in general psychiatry and the psychiatry of old age have fallen from 13,796 in 1990-1991 to 7,561 in 2000-2001. However, there are still a large number of people with severe and enduring mental illness living in adult continuing-care wards.

Through our visit programme and from recent investigations we have concerns about the quality of life of those people who continue to live in hospital. We decided to carry out a number of unannounced visits to continuing-care wards and ‘slow stream’ rehabilitation wards for people who have severe and enduring mental illness (not dementia).

The main purpose of these visits was to get the views of patients who were unlikely to be able to contact us during our usual hospital visits and to build a picture of the quality of life for people who are living in in-patient continuing-care wards or units. We wanted to gather information and gain an impression on what it is like to live in the wards and units we were visiting. For example, does the person we were visiting have, as far as possible, a reasonably fulfilling life? Is he or she recognised by the service as an individual with his or her own wishes? Is his or her freedom of movement unnecessarily restricted? Does he or she have ordinary experiences like shopping for their own clothes and personal items or going to the cinema or theatre outside of the hospital or unit? Do staff actually know their patients and communicate in a meaningful, and respectful, way with them?

The visits also gave us the chance to gather information from staff on some of the issues mentioned above, for example, systems of reviewing patients, arrangements for physical health care, the general availability of appropriate activities, therapeutic interventions and resources such as using appropriate staff consistently.

## 2. HOW DID WE CARRY OUT THESE VISITS?

In January 2003 we visited 18 wards and units from Dumfries to Inverness. Each visit was carried out by two of our representatives and lasted around two hours. We carried out the visits over a period of a week and they took place at various times during the day and early evening. We carried out structured interviews with 30 patients and met and spoke informally with many more, either individually or in groups.

### 3. WHAT WE FOUND:

We do not underestimate the challenge for staff in caring for people whose illnesses are severe enough that they have to live in hospital. Those illnesses often lead to an apparent lack of motivation and lack of interest in life outside the ward. We did see a few attempts at creative approaches to getting people with severe illness involved in activities that may have therapeutic benefit and enrich their lives. We saw a few examples of accessing local community and educational facilities. We saw some attempts at promoting the use of befrienders. We saw efforts at promoting a homely environment and working to develop links with patients’ councils and local advocacy services. However, these efforts were quite rare and we were left with many concerns. Staff complained about the lack of finance for activities outside the care setting and for transport. We were left with an impression that life, with very few exceptions, is likely to be dull for those who live in hospital. We think that staff can have too low expectations of what is possible for people in continuing-care settings and that they underestimate the benefits of helping people to be more involved in life outside hospital. There appears to be a lack of importance given to making sure that patients have access to a private telephone. There is an apparent low priority given to using advocacy services.

Staff clearly believed that all their patients either had a personal plan of activities off ward or access to activities at the time of our visits (that took place at various times during the day). However, at the time of our visits, 90% of the total number of patients who were living in the wards we visited were present in the wards at the time. It is important to remember that a large proportion of this group of patients’ lives is being spent in hospital. Around 57% of the patients in the wards we visited have been living in hospital for over 10 years (see chart 1 in appendix 1).

#### a) **Planning care**

We asked staff if they held regular meetings to plan care for their patients and if all patients had individual care plans. Staff in every ward we visited said that all their patients had individual care plans and that these were regularly reviewed which involved the patient, nursing, medical and other staff. The frequency of care-planning meetings for each patient ranged from one to 12 months. It was reported that attendance by various disciplines of staff varied according to the need staff believed was there. In some wards, social work staff only attended when staff were considering discharging a patient from hospital.

Information from our interviews with individual patients showed that reviews were largely taking place as described. However, five of the 30 patients we interviewed had no case history in their records. We believe it to be very important that a clear case history is available to make sure that care staff and staff making treatment decisions are fully aware of the patient’s background and clinical history. All the patients we interviewed, except two, had a care plan and all of the care plans showed evidence of a review within the last 12 months.

While all of the units we visited reported that they involved patients in planning their care, the message from most of the patients we visited was that they;

- were not aware what their treatment was apart from medication;
- were not aware of what the medication was for; and
- did not give us an impression that they were involved in their care.

## b) Consent to treatment and the Adults With Incapacity (Scotland) Act 2000

We were struck that only two of the patients we interviewed had completed certificates of incapacity in their medical files. Most patients we met had very limited knowledge or understanding about their treatment. We found it hard to accept that many of the patients we met were in a position to give informed consent to their treatment.

**Table 1 – Planning care**

Hospital or care unit	Ward	Individual plans	Regular reviews	Frequency (months)	Who is involved?	Health reviews	Frequency (months)
Ailsa	Crossraguel	Yes	Yes	6	PMNOS	Yes	6
Bellsdyke	Trystview	Yes	Yes	1	PMNOO	Yes	Y
Borders	Galavale	Yes	Yes	1	MNO	No	As necessary
Crichton	Lahraig	Yes	Yes	6	PMNOSRA	Yes	6
Dykebar	Ward 9	Yes	Yes	1	PMN	Yes	12
Hartwoodhill	Gigha	Yes	Yes	1 and 12	P(M)NSRA	Yes	12
Hartwoodhill	Skye	Yes	Yes	1 and 12	PN (M)	Yes	12
Highland	Drumboe	Yes	Yes	6	MNS	Yes	No system
Leverndale	Southview	Yes	Yes	12	PMNSRA	Yes	12
Lochgilphead	Arran	Yes	Yes	1	PMNSRA	Yes	As required
Murray Royal	Almond	Yes	Yes	3	PMNOSR	Yes	3
Royal Cornhill	Fyvie	Yes	Yes	3 to 6	PMN	Yes	12
Royal Edinburgh	Swanston	Yes	Yes	6	PMNORA	Yes	12
Royal Edinburgh	Craiglea	Yes	Yes	3	PMNOSRO	Yes	6
St Johns	ICCU	Yes	Yes	12	PMNOSRA	No	Ad Hoc
Stratheden	Falkland	Yes	Yes	1 to 3	PMNORA	Yes	'Continuous'
Stratheden	Lindores	Yes	Yes	3	PMNR	No	Does not apply
Stratheden	Kinnaird	Yes	Yes	Varied	PMNOSA	Yes	6 to 12

P(patient) M(medical) N(nursing) O(occupational therapy) S(social work) R(relative) A(advocate)

Medical staff involved in annual reviews

## c) Physical health care

Phelan (2001) in a *British Medical Journal* editorial wrote “Over 60 years ago the BMJ reported an association between mental illness and poor physical health. Subsequent research, in many countries, has consistently confirmed that psychiatric patients have high rates of physical illness, much of which goes undetected.”

Most of the 18 wards we visited reported that there was a system in place to make sure regular health reviews were carried out. However, three wards reported that there was no system. In six cases there was no evidence of a physical health-care review in the last 12 months. Interestingly, the patients who had no record of a physical health review all lived in wards where staff reported that there **was** a review system.



We believe that staff must carry out regular reviews of the physical health of patients in continuing-care settings. The aim must be to improve the physical health of those people with severe mental illness. However, simply reviewing the physical health of patients in continuing-care settings is not the end of the story. Staff should think about working with patients to encourage them to take regular exercise, eat healthily and help, when patients' want, to reduce or stop smoking.

**d) Activities**

We asked staff:

- if patients had their own activity programmes;
- who is involved in the activities; and
- if there are activities outside the ward or unit.

Thirteen of the 18 wards reported that patients had individual programmes. Of the patients we interviewed, around 50% had their own programmes. It was reported that in all the wards nurses were involved in activities. In 12 wards Occupational Therapy was involved, in six recreation and activity staff were involved and in four wards volunteer staff were regularly involved. In all but one of the wards staff said that patients had access to other activities.

**e) Inclusion**

We were interested to see how involved patients were in their treatment and what opportunities there were for getting involved in life outside the ward or unit they were living in. In all of the wards except one, staff reported that patients had the opportunity to be involved in discussions about their care and eight reported that advocates were involved. However, only one of the 30 patients who asked for an interview had an advocate, although 15 wards reported that patients had access to advocacy. Ten patients told us that they had visitors, some only very occasionally. None of those people we interviewed had a befriender although staff in eight wards reported that there was access to befriender schemes. Only five of the 30 patients we interviewed had had any kind of holiday away from the ward in the past two years. We were concerned to find that in eight wards there was no access to a phone with a reasonable degree of privacy.

**f) Written information**

Of the 18 wards or units we visited, ten had some form of written information for patients. The information ranged from a restating of named-nurse policies and a copy of the patient's charter, to leaflets that gave more detail about life in the particular ward. We believe that using written information more would benefit the patients we visited. We think it would be helpful for people in hospital to have written information about such things as:

- treatment;
- activities;
- what to do if you have a question about your care;
- personal finances; and
- how to arrange to go to the shops.

We also thought that given the uncertainty about their treatment many of the patients appeared to have, access to their own treatment plan would be a useful way of helping people to understand their current treatment and plans for the future.

**g) Personal finance**

Weekly income for the individual patients we visited ranged between £3.50 cash (plus cigarettes bought for the patient) to £31.40, with most patients visited receiving the basic personal allowance of around £15 a week. While we did not ask detailed questions about how personal funds are managed we think it is important that people in continuing care have opportunities to manage their personal money and are able to access shops and services in as normal a manner as possible. Around 44% of the patients currently living in the wards we visited have been declared incapax. However, our impression was that there were greater opportunities to include budgeting and personal choice in the patients' day-to-day lives.

Staff in many of the wards we visited reported that there were limited funds available for rehabilitative activities and to support a social life for patients outside the care environment.

In one ward we identified that a patient had recently been served with a writ in connection with a Council Tax debt. Staff were not sure about the legal position and had allowed Sheriff's Officers to serve the writ despite the patient receiving benefits. Our further enquiries have led to the hospital giving staff guidance on how to deal with these situations in the future.

Few staff were aware of what the effect of introducing Part 4 of the Adults With Incapacity (Scotland) Act 2000 would be.

**h) Delayed discharges**

Of the 392 patients living in the wards we visited staff reported that there were ten patients whose discharge was currently delayed for over a year. Four patients were delayed for between two and three years and two patients were delayed for over three years. We were not told that there were particular problems in getting assessments carried out but it is clear that the drive to move patients from hospital wards is often due to the unit closing down.

**Table 2 – Nurse staffing**

Hospital	Ward	Agreed		Actual		Bank
		R	N/R	R	N/R	
Ailsa	Crossraguel			1	3	
Bellsdyke	Trystview	2	7	2	7	
Borders	Galavale	2	1	2	1	
Crichton	Lahraig	3	2	3	2	
Dykebar	Ward 9	2	5	2	5	1
Hartwoodhill	Gigha	2	2	3	2	
Hartwoodhill	Skye	2	2	2	2	
Highland	Drumboe	2	3	2	2	
Leverndale	Southview	6	3	6	3	
Lochgilphead	Arran	2	2	1	2	1
Murray Royal	Almond	1	2	2	1	
Royal Cornhill	Fyvie	2	3	2	3	1
Royal Edinburgh	Swanston	1	3	1	2	1
Royal Edinburgh	Craiglea	2	4	1	4	
St Johns	ICCU	2	3	4	1	
Stratheden	Falkland	2	2	3	1	
Stratheden	Lindores	2	2	1	2	
Stratheden	Kinnaird	3	1	3	1	
<b>Totals</b>		<b>38</b>	<b>47</b>	<b>41</b>	<b>44</b>	<b>4</b>

R – registered nurse N/R – non-registered nurse

### i) Available nursing staff

We believe that consistent staffing is important in providing continuing care. Because of this we thought it appropriate to ask what staff were available at the time of our visit. We asked what the agreed level of staffing was and what staff were actually on duty at the time of our visit.

As we can see in table 2, the agreed staffing levels reported to us were a total of registered and unregistered nursing staff of 85. At the time of our visit there were 85 staff on duty including a total of four bank staff. It appeared that staffing levels were being met without relying too much on bank staff who may not know the patients in their care.

### j) The environment

We asked our visitors to give their impressions of the wards we visited. Many of the facilities we visited were wards in old institutions, some of which had been refurbished to a certain degree. Of the 18 wards and units we visited, 11 had some form of dormitory accommodation. The patients we spoke to seemed to want single rooms and they would certainly offer more personal private space. However, in one ward, patients commented that because there was no way of locking the door to their rooms they often felt quite vulnerable. We believe that it is entirely reasonable for patients to be able to lock their own bedroom door. If there are concerns about patient safety, there are systems that allow staff to override bedroom door locks. We were disappointed to see how few wards provided lockable secure storage for patients’ personal belongings. We believe this is all the more important for people who have to share accommodation.

We were struck by the wide variation between wards and units in arrangements for patients' access to kitchens. Some wards actively encourage patients to make snacks or hot drinks. In others staff reported that kitchen areas were locked for safety reasons. On the one hand there seemed to be a view that opportunities to make snacks when patients wanted was very reasonable and an important part of rehabilitation. On the other hand, staff were clearly worried about patient safety. Our view is that continuing-care settings should provide as normal an environment as possible and promote activity such as making hot drinks and snacks. Clearly there may be safety issues but we think if kitchens are kept locked, clinical staff and managers should reassess the reasons for this and consider strategies that allow patients as much access as possible while maintaining a safe environment. Simply locking a door may be an easy option.

We were very concerned that in 11 of the 18 wards or units we visited there was no access to drinking water for patients outside mealtimes without asking staff. This is completely unacceptable. Patients must have access to drinking water without having to ask. In one ward we were told the kitchen was locked because patients would 'drink water all the time'. There appeared to have been no thought given to why this might be – perhaps as a result of side effects of medication, or whether it was all patients, a few or just one. Every ward or unit must provide access to water for patients, preferably from a running source and not from jugs.

#### **k) Locking doors**

Of the 18 wards three were locked at the time of the visit. All three of these wards were locked at all times with one having a written policy on the door being locked. The three wards had a total of 102 patients of whom 18 were held under the Mental Health (Scotland) Act 1984 (around 18%). Interestingly, the percentage of patients held under the act in the unlocked wards was 82 out of 187 patients (around 44%). Of the unlocked wards some did lock the door occasionally for clinical reasons with four out of the 15 having a system of recording when the door was locked. Three of these wards had a policy for staff on locking the door.

## 4. OVERALL IMPRESSIONS

We met many staff fully committed to providing good and creative care to patients. We saw some small facilities that provided care and support to people with severe illness in a domestic setting. We saw evidence in some settings of regular and detailed care reviews, with it being clearly recorded that proper attention was being paid to patients’ physical health. However, we also saw large institutional wards where patients slept in dormitories with limited personal possessions and personal space. We were not convinced that the arrangements for patients in some wards meant their care and treatment was reviewed well enough. We did not think enough attention was paid to encouraging contact with community facilities to help reduce, as far as possible, the effects of living in an institution. We were struck by how many patients in the wards were apparently not involved in any kind of activity at the time of our visits.

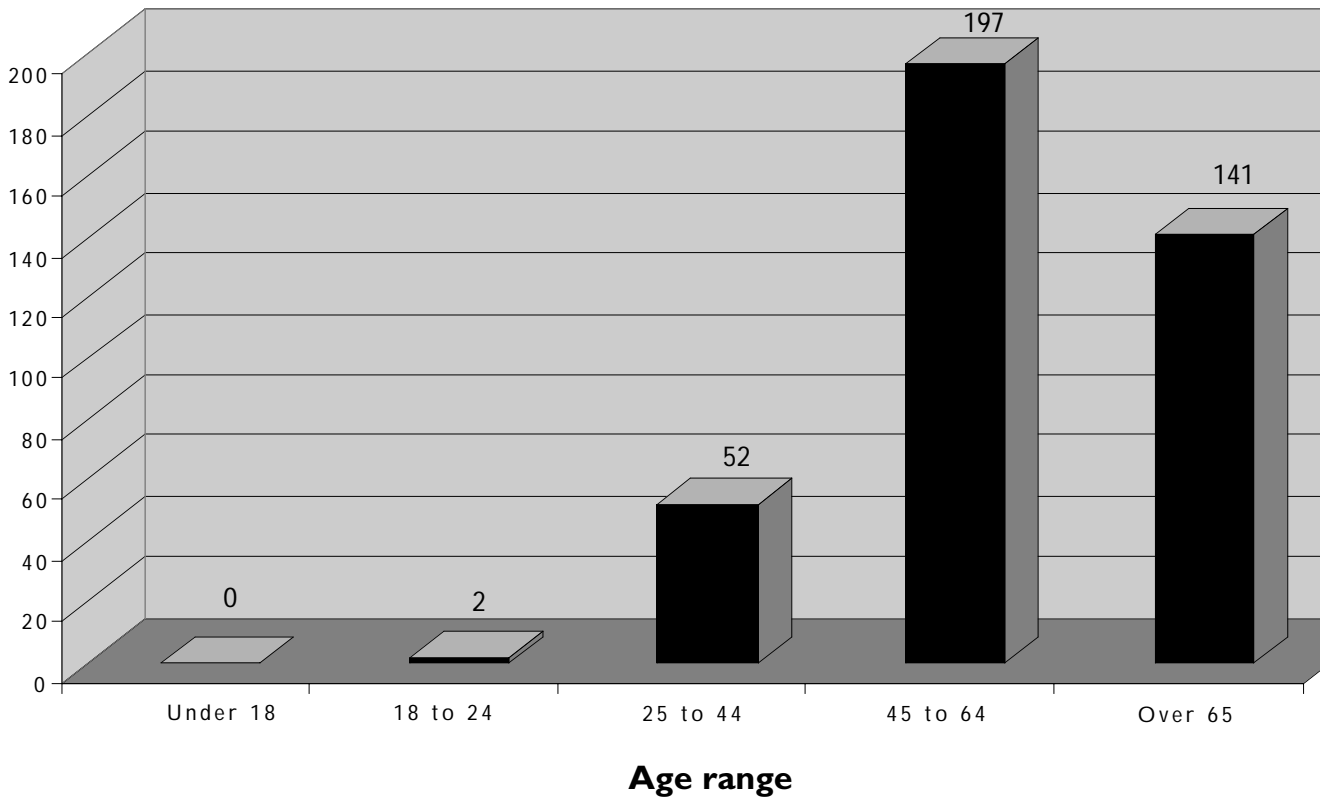
Some people we visited spoke highly of the staff who were helping them and the facilities they were living in. However, many of the patients we visited were not happy with their lives in hospital. Patients in one ward told us ‘it’s not a life’ and said when asked about activities ‘nothing, never anything’ and ‘we’re just incarcerated’.

In general we believe that staff and patients should have greater expectations of what can be provided and achieved in continuing-care settings. We will continue to discuss, on our visits to services, the issues that have arisen locally. We will also raise the issues arising from these visits with the Scottish Executive.

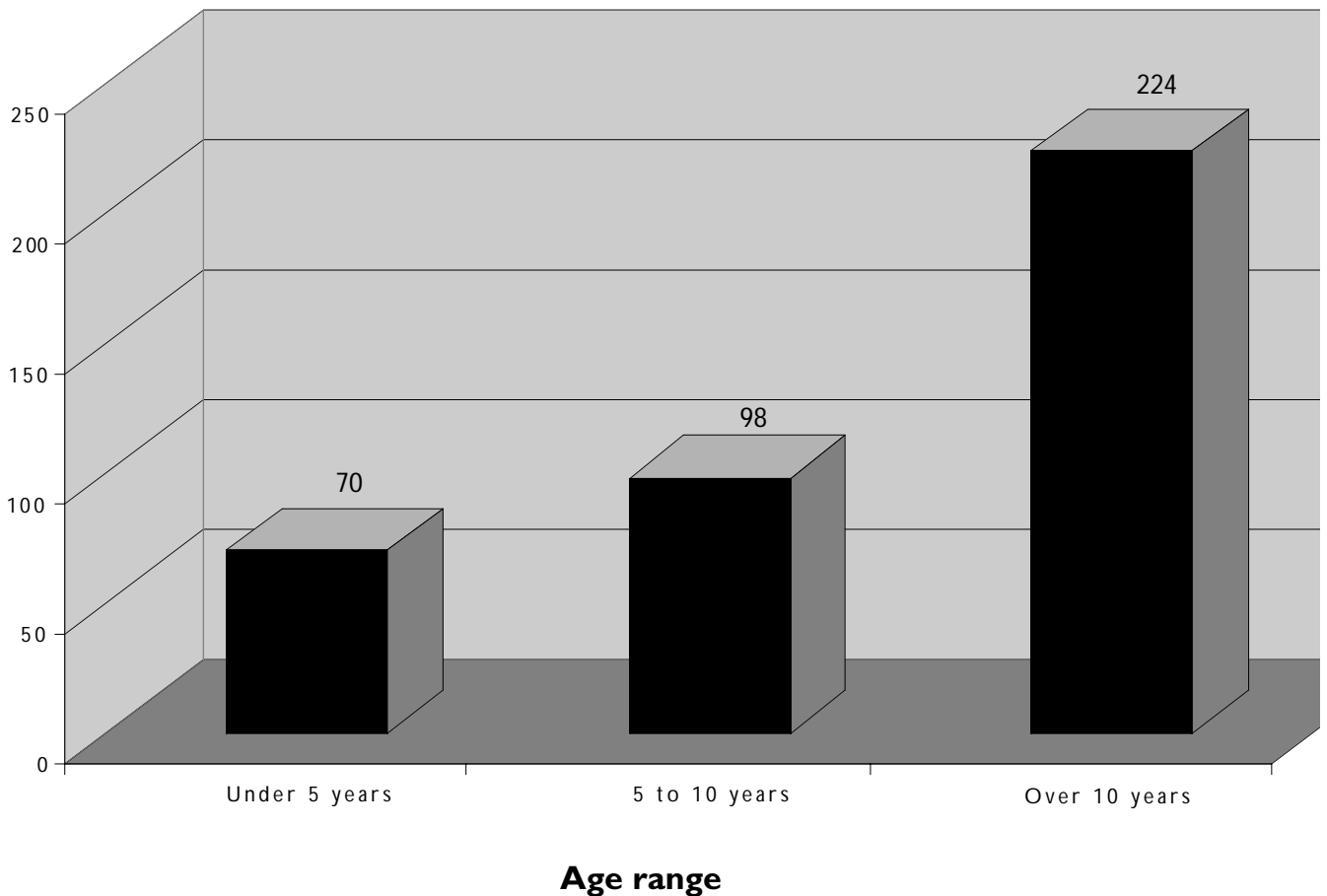
We appreciate that many services have plans to move their current continuing-care services to more domestic-type settings. However, many patients continue to live in what we can only describe as dull and drab institutional settings. No matter what the environment, staff must provide proper skilled treatment and activities to reduce any possible effects of living in an institution, reduce distress and to encourage people to mix more, as far as possible, with life outside the particular care setting. We have included in this report a checklist (appendix 3) which we have drawn up from the issues that arose during our visits. We would encourage managers and clinical staff to take a fresh look, preferably with the involvement of patients, at their continuing-care services. They need to identify improvements that will provide a better life for those people with severe and enduring illness who need high levels of support. We think that we should all have far greater expectations of life for people receiving continuing care.

# APPENDIX I

**Chart 1 – Age range of patients in the wards and units at the time of the visit**



**Chart 2 – Length of stay**



## APPENDIX 2

### BIBLIOGRAPHY

Phelan, J (2001) Physical health of people with severe mental illness. *British Medical Journal* 322, 443-444.

# APPENDIX 3

## Checklist for managers of continuing-care facilities

		YES	NO	DON'T KNOW	ACTION REQUIRED
1	Do all your patients have their own care plan with a clear case history?				
2	Is there an effective system for making sure regular case reviews are carried out?				
3	Are all appropriate staff, relatives and advocates involved in case reviews?				
4	Is there a system of audit to make sure reviews are taking place at agreed time intervals?				
5	Is there a system to make sure regular physical health reviews are carried out?				
6	Is there a system of auditing health reviews?				
7	Is there a system to make sure that you have assessed the ability of all patients to give informed consent to treatment?				
8	Is there a system to monitor high-dose medication for mental disorder?				
9	Is there an advocacy service available to patients and is information about the service available to patients?				



		YES	NO	DON'T KNOW	ACTION REQUIRED
10	Is there a system (with clear, understandable written information) to make sure that patients, as far as possible, are aware of their treatment and care plans?				
11	Is there written information for patients on what activities are available in and out of the ward?				
12	Is there written information and a system of explanation for patients about how personal money is managed in the ward or care setting?				
13	Is there a system to audit what activities patients are actually involved in?				
14	Do patients have lockable storage facilities?				
15	Do patients have access to water or drinks without asking?				
16	Do all patients, where possible, go on a regular holiday?				
17	Is there a written policy and procedure about locking doors within and outside of the ward or unit?				
18	Has there been a recent review of the environment of continuing-care facilities in your service?				

# CONTACT US

If you feel you would like to discuss any matter with us you can contact us, in confidence, in the following ways:

- By phone: 0131 222 6111
- By email: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)
- At our website: [www.mwscot.org.uk](http://www.mwscot.org.uk) You can use our web site to ask for help or to get our full Annual Report and other publications.
- In Writing: Mental Welfare Commission for Scotland, K Floor, Argyle House, 3 Lady Lawson Street, Edinburgh EH3 9SH.

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