Mental Welfare Commission for Scotland

Report on announced visit to:

Oak Tree Ward, East Lothian Community Hospital, Alderston Road Haddington East Lothian EH41 3PF

Date of visit: 14 June 2022

Where we visited

Oak Tree Ward is a recently built 20-bedded mixed ward in East Lothian Community Hospital, providing care for older adults with functional mental illness, as well as those with dementia who require in-patient assessment or continuing HBCCC (hospital based complex clinical care).

Prior to Oak Tree Ward opening in late 2019, the Commission was advised of changes in the planned patient population and remit of the new purpose-built ward. In addition to caring for patients who required dementia continuing care (HBCCC), the new service would also be providing care for older adults with acute functional mental illness and those requiring inpatient assessment for dementia. We shared concerns at the time about the suitability of the environment for patients with such diverse needs and made recommendations then, and again following our last visit, on 16 November 2020, about reviewing the ward environment.

Other recommendations following the Commission's last visit related to improving risk assessments and the communication of risk information from community teams at the point of admission and reviewing psychology provision to the service, to ensure arrangements for psychology support were in place.

This visit was arranged to follow up on the previous recommendations and to meet with patients and their relatives to review their care and treatment.

Who we met with

We reviewed the care of seven patients and spoke with two sets of relatives.

We met with the chief nurse, service manager, the senior charge nurses, other nursing staff and consultant psychiatrists.

Commission visitors

Juliet Brock, medical officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

The ward was at capacity on the day we visited. Patients who were able to speak with us and tell us about their experience were positive about the staff and the care they were receiving. The family members we spoke with were also complimentary about the care their relative received, with the families of two patients telling us their relative was well looked after.

We heard from nursing staff and the psychiatrist that the ward was consistently well staffed, although we were advised that staff were sometimes "pulled elsewhere" to support other services, which could limit patients' opportunities for activities and outings. One patient's family commented that although their relative was well looked after, the ward felt understaffed to them, especially at weekends. It was however encouraging that, despite national challenges in nursing recruitment, we were advised that the nursing team were experiencing no retention or recruitment issues and had recently appointed new band 6 and 7 nurses.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based on site or accessible to them. In addition to nursing and medical staff, this included an occupational therapist (OT) and OT assistant, two activity co-ordinators, psychologist and music therapist. Additional support from physiotherapy, speech and language therapy or dietetics could be accessed on referral.

Care records

Patient care records were mainly held on the electronic record management system TRAKcare. We found 'Getting to know me' documents completed for most, but not all of the patient records that we reviewed. Overall, from the files we reviewed, we thought there could be improvement in written recording in a range of areas.

Daily entries from ward staff varied in quality and in the level of detail provided. Our impression was that there was often a focus on negative rather than positive aspects of patient presentation that were recorded daily. Language used was also negative at times and we found examples of unhelpful descriptions of individual patients' behaviours that appeared to reflect negative value judgements. Where episodes of patient distress were recorded, use of medication frequently appeared to have been the first line of action; there was often no reference to potential antecedents, or of non-pharmacological strategies being tried.

We found detailed recording by physiotherapy. There were no notes made in the TRAKcare records by the activity co-ordinators. There was little reference to patients being invited to take part in activities, or their participation in any of the many activities on offer, in the notes we reviewed.

Following our last visit we made recommendations about improving risk assessments. A detailed action plan was provided in response. It was a concern that on this visit mental health risk assessment appeared to be missing in a number of the files we reviewed. We discussed this with senior staff on the day.

Records of MDT meetings clearly listed those in attendance. The detail of MDT discussions varied, the ongoing action plans could sometimes have been clearer.

Care plans

Nursing care plans were variable in quality and reviews were inconsistent. Some had a good level of person-centred detail, but this was not a consistent finding. We thought there could have been more focus on patient strengths in some of the care plans we viewed. Some stress and distress care plans had a good level of personalisation; we felt these could have been even better with the addition of a patient formulation. We discussed this with senior staff of the day. We noted the positive addition of part time psychology input to the ward since our last visit and discussed whether this support could further improve patient formulation and stress and distress care planning.

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

Recommendation 1:
Managers should ensure nursing care plans are person centred, strengths based, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

Recommendation 2:
Managers should review care planning and initiate improvement work, ensuring that all care plans include a summative evaluation indicating the effectiveness of the interventions being carried out and any required changes.

Use of mental health and incapacity legislation

On the day of our visit, 11 of the 20 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Documentation pertaining to the Mental Health Act and the Adults with Incapacity (Scotland) Act 200) (AWI Act) was in place in the files we reviewed.

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, however we found a number of instances where individual medications prescribed were not properly authorised by the patient's T3.

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 found section 47 certificates in place, with accompanying treatment plans, for most of the patients for whom this was required, however there appeared to have been gaps in the authority to treat for two patients.

For patients who had covert medication in place, we found appropriate documentation in place. The Commission has produced good practice guidance on the use of covert

medication:
https://www.mwcscot.org.uk/node/492

Recommendation 3:
Medical staff must ensure the required legal authority for treatment is in place for all patients who are subject to the Mental Health Act or AWI Act. When a patient has a T2 or T3 in place, the responsible medical officer must ensure that any newly prescribed treatment is properly authorised.

Rights and restrictions

Oak Tree Ward continues to operate a locked door, commensurate with the level of risk identified with the patient group.

We heard that there was access to advocacy support and that some detained patients on the ward had accessed this support.

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

At the time of our last visit, two activity co-ordinators had just been recruited to the team. We were pleased to hear on this visit of the positive impact this support had made. The activity co-ordinators, who were able to provide input to the ward seven days a week, provided a range of one-to-one and small group activities to support individual activity programmes. We heard positive feedback from some individual patients we spoke with, particularly in relation to music activities on the ward. It was disappointing that the evident range of activities that were taking place was not reflected in patients' files. Better recording would evidence the positive therapeutic opportunities being offered to patients.

Occupational therapy input to the ward enabled individual assessments to be carried out and provided assistance in planning activity programmes for individual patients.

In addition, a music therapist visited weekly and there was input from 'Music in Hospitals'. We were also told of a few occasions in which a pop-up cinema had been set up, including to live stream the Queen's Jubilee celebrations.

Through charity funding the ward had been able to acquire a mobile touch screen unit for patients to use. Known as RITA (Reminiscence Interactive Therapy Activities), this system enables patients to access music, information and activities such as games and puzzles according to their individual interests. It can also provide calming images to support patients at times of distress. We were told this had helped reduce the use of medication for acute distress.

Staff told us that funding had also been agreed to acquire a seven seater people carrier to enable patient groups to be taken out. Staff told us that an approach of positive risk taking was being adopted and that this would enable some patients to participate in more activities

in the community. Examples of planned trips included dementia-friendly performances at the Festival Theatre.

The physical environment

The ward was only a few years old and in general we found the environment to be clean and well maintained. The large open plan living/dining space was light, bright and welcoming. There were comfortable soft furnishings, pictures on the walls and items of visual interest, as well as a piano. Additional shared spaces around the ward included a salon (which staff had equipped through fundraising), an activity/therapy room and a smaller relaxation lounge that families could also use for visits.

There was dementia-friendly signage around the ward and a photo board in the corridor showing activities on offer. The addition of artworks around the ward added interest and there were a number of small seating areas around the corridors which offered quiet, welcoming spaces for patients to sit.

The spacious garden area, accessed via the communal lounge, had lots of seating available for patients. Staff said the outdoor space was well used in the warmer months. We were advised of plans to level a large sloped part of the garden to improve accessibility for patients. Funding had been identified and contractors were awaited to undertake this, in addition to other improvement work planned for the garden.

The two main bedroom corridors were designated for patients with dementia diagnoses. All bedrooms had en-suite shower facilities. We noted positive design features that had been added to patient bedrooms, such as personalised boxes and pictorial information, designed to help patients with orientation.

There was a separate annexe of four bedrooms in a different part of the ward which was used for patients with functional mental illness. At the time of the Commission's last visit, this annexe was about to be put into use. We shared some concerns about the utility of the space for the patient group at the time. This was in relation to potential environmental risks and the lack of recreational or therapeutic space available for these patients. The action plan provided by the service in response to the Commission's recommendations and additional correspondence at the time, detailed plans for a revised layout of the ward. The proposed design had been developed in consultation with the clinical team and had been put forward as a proposal for commissioning.

It was disappointing that on this visit, eighteen months later, this work was still awaited. Senior managers advised us of significant challenges in the process, including high estimated costs. We were shown the way in which the main bedroom corridors would be re-configured to incorporate a separate therapeutic unit for patients with functional illness.

On this visit we viewed the bedrooms in the four-bed annexe used for patients with functional illness and had ongoing concerns about certain aspects of the environment. Although we understand these bedrooms had been designed to be safer, we remained concerned about the presence of multiple ligature points. We raised these concerns with senior staff on the visit, particularly in the context of the risk profiles of some patients whose care we had reviewed. We were assured by the team that risk assessments identified any individuals of

concern and that enhanced levels of nursing intervention were used where required to mitigate any environmental risks. We have asked that managers keep us updated of progress in relation to the environmental concerns that we have raised with them.

Any other comments

Delayed discharges

We were pleased to be advised that the number of delayed discharges had reduced. The main reason for delays was primarily a lack of care home placements. This in turn had led to concerns that patients who were acutely unwell in the community could not be admitted and East Lothian patients having to be admitted out of area at times.

We were advised that a new 10-bedded NHS enhanced care unit, Crookston, was being set up in the community. This new unit was to occupy a former care home in Tranent. It was envisaged that the new unit would have two flexible beds that could be used for interim care for patients from the ward whose discharge was delayed and who were awaiting a package of care in the community. We know that multiple moves can be challenging and disorientating for people with dementia, but we also recognise that a lack of available in-patient beds has, at times, led to delays in admitting patients who urgently require specialist mental health care. At the time of our visit, the senior charge nurse from Oak Tree Ward had been seconded to help set up the new nurse-led service. We have asked NHS Lothian to keep us advised of progress with Crookston.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing care plans are person centred, strengths based, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

Recommendation 2:
Managers should review care planning and initiate improvement work, ensuring that all care plans include a summative evaluation indicating the effectiveness of the interventions being carried out and any required changes.

Recommendation 3:
Medical staff must ensure the required legal authority for treatment is in place for all patients who are subject to the Mental Health Act or AWI Act. When a patient has a T2 or T3 in place, the responsible medical officer must ensure that any newly prescribed treatment is properly authorised.

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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