Mental Welfare Commission for Scotland

Report on unannounced visit to: Rowan Unit, Susan Carnegie Centre, Stracathro Hospital, Brechin, DD9 7QA

Date of visit: 25 October 2023

Where we visited

Rowan Unit is based in the Susan Carnegie Centre and is part of the old-age psychiatry units in the grounds of Stracathro Hospital in Brechin. It is a mixed-sex unit with 13 beds providing admission, assessment and treatment for older people with functional mental health problems. Admission to the ward is through the older people's mental health multidisciplinary teams that are based across Angus.

We last visited this unit as part of the Commission's themed visit to older people's functional mental health wards in 2019.

On the day of this visit we wanted to speak with individuals, relatives and staff. We also wanted to find out how the service was implementing the recommendations from the Commission's themed visit report that was published in April 2020, *Older people's functional mental health wards in hospitals*.

Who we met with

When we plan an announced visit, prior notice is given to individuals and relatives of our intention to visit. This visit was unannounced, therefore we were unsure if we would have the opportunity to speak with relatives, as well as those individuals on the unit on the day. We managed to speak with nine individuals and one relative. We also reviewed the notes of six individuals.

On the day of the visit, we spoke with the senior charge nurse (SCN), ward-based nursing staff and senior managers.

Commission visitors

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

Feedback about the staff team from individuals and relatives was positive. Individuals described staff as “kind”, “caring”, “helpful”, “wonderful” and told us the staff “look after us”. Most individuals were able to tell us about their involvement in their care and treatment and about their journey to recovery, whilst others told us about their discharge planning. We were told that the communication with families was good and that individuals felt involved in discussions about their care and treatment. Some told us that they saw their consultant psychiatrist regularly, whilst others told us that they did not. We heard from individuals and the relative that the internet connection was not good in parts of the ward.

Individuals described the food as good and everyone told us that they liked having their own room, providing them with privacy. Most individuals and the relative told us that there was not enough to do on the ward and that the days could be long and boring.

Some individuals told us about their trips out of the ward with the activity co-ordinator and how much they enjoyed this, but this did not happen regularly. We heard that having access to the enclosed garden space was good, particularly in the nice weather.

The SCN and managers told us about the effects of the recent storm ‘Babet’ that had hit Brechin, where many residents had to be evacuated from their homes. We were told that the health board and the health and social care partnership (HSCP) had to implement their emergency priority response plans due to the crisis. This resulted in some staff having to sleep in the hospital to provide cover to the patients, as many staff had been affected by the storm.

The SCN told us that there were currently no staffing vacancies in Rowan Unit and that they do not use agency staff but at times have used bank staff. Managers told us that the positive staffing situation in the ward was due to the temporary closure of another ward in the service.

We were told that since the Covid-19 pandemic, the input from occupational therapy (OT) had increased and that the unit now had dedicated input from an OT and OT assistant. The SCN told us that the Angus Carers Centre ran a fortnightly drop in that provided support to carers; this had been beneficial for carers and improved communication and links with the staff. We were told that the unit continued to have good links with the local advocacy project who visited the unit regularly and provided support to all individuals where required.

The SCN told us that the health and well-being team had been meeting with the staff group regularly and the staff had been receptive to this. We were told that there had been staff sessions around values-based reflective practice, however sessions had been paused in the meantime due to staff changes in the wellbeing team.

Care planning and documentation

We viewed care plans and found that they were detailed, person-centred and holistic, covering a wide range of physical and mental health needs. There was evidence of regular review of the care plans however, the level of detail was variable in the review process and we would have wanted this to be more consistent. We wanted to find out about individual involvement in the care planning process; we saw care plans that were signed or had recorded that they

had been discussed with the individual, whereas others recorded that the individual was unable to sign.

In the individual's file, detailed nursing assessments had been completed at the point of admission and had been updated throughout the individual's journey, along with detailed risk assessments and risk management plans.

Where we found evidence of one-to-one discussions in individuals' files, we found some entries were detailed, however this was inconsistent. We found some people had regular one-to-one sessions with staff and were able to tell us about the benefits of those sessions. Where none were recorded, it was not clearly evidenced if the individual had been offered one-to-one contact or refused it if this had been offered. The level of detail in the daily nursing entries was also variable. We found that some were very detailed, although other entries recorded non-descript phrases, such as the individual being "evident around the ward".

We asked managers about the audit process that was in place and were told that there were regular monthly audits of the care records, including the electronic records.

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)

We were told that there was one consultant psychiatrist who covered the ward and that a weekly MDT meeting took place.

The ward had input from a wide range of professionals that contributed to individuals' care and treatment. The MDT consisted of consultant psychiatrists, psychology, OT, and an activity co-ordinator. There was also input from pharmacy at the MDT meeting and we found there was good attention to the link between physical and mental health care in the individual records. Staff told us that individuals had regular access to allied health professionals, such as dietetics and physiotherapy, which we saw on the day of our visit.

We were told that for every individual who was admitted to the ward, a formulation plan was developed by the psychologist, which we felt was positive.

We were told that there was an electronic MDT document (Scamper) and that each professional recorded on the document before the MDT meeting. Scamper is a structured clinical assessment and communication tool intended to highlight key clinical tasks to be completed for individuals and to ensure that their care progresses without gaps or delays. We were disappointed to find documents that had very little detail, lacked reviews, and recording overall progress. We found that the tools the unit had in place appeared robust however, were not being used effectively. We were told that there was an adopted, unified approach across NHS Tayside to use this document however, we found there to be a lack of review, recording of actions and progress.

We asked about individuals' participation or involvement at the MDT meeting. We were informed that individuals could attend as well as their relative however, if they could also meet with the doctor out with the meeting if they preferred.

We did find some examples where individuals' views had been sought in advance of the meeting, and individuals told us about attending the meeting. We were pleased to see that there appeared to be a consistent approach for individuals to be involved in ongoing discussions about their care and treatment, and about their recovery journey.

We asked the SCN about patients who were recorded as delayed discharge. We were told that there was an effective process and multi-agency working across Angus HSCP for individuals who were delayed, and good links with the community mental health teams.

Recommendation 1:
Managers should review the current MDT documentation and ensure that the record captures the MDT weekly discussion, along with the recorded actions and outcomes, including individuals' views about their care and treatment.

Use of mental health and incapacity legislation

On the day of our visit, six patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) and we found the documentation that related to the individual's legal status. For one individual, we found that the incorrect legal status was recorded in the notes and brought this to the SCN's attention.

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. Certificates authorising treatment (T2 or T3) are required to be in place and we found this was the case. In most cases these corresponded with the prescribed psychotropic medication. However, we found one T3 certificate that provided authorisation for one anti-psychotic medication, although the prescribed treatment differed from this, meaning that this treatment was not authorised on the current T3 certificate. We had been informed that the medical staff were dealing with this however, we also brought this to the manager's attention.

We found that there were two individuals who had been prescribed intramuscular (IM) 'as required' medication, but that this was not authorised on the treatment certificate for one patient and the other patient was not detained under the Mental Health Act. The Commission has concerns about IM 'as required' medication being prescribed for informal patients, as it would be unlikely that this would be administered under conditions of consent. If the patient was so distressed and exhibiting behaviour which caused concern, then their legal status would need to be reviewed and any additional 'as required' medication prescribed at that point. We heard that there were occasions that the doctor would prescribe in advance due to individual circumstances, but this should only be for patients who were detained under the Mental Health Act. We were told that the advance prescribing was due to the rural location and out of hours cover, however the unit was due to implement HEPMA (Hospital Electronic Prescribing and Medicines Administration) in the near future, which will resolve this issue as this system will provide a single digital solution for prescribing and managing medicines.

For patients who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act 2000, we saw copies of the legal order in place apart from in one case, which we brought to the manager's attention.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan 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, who has relevant powers and record this on the form. We found some that were very detailed and completed in accordance with the AWI Act code of practice for medical practitioners however, there was one certificate that we brought to the attention of the managers, as the certificate had expired.

On reviewing individuals' notes, we were pleased to see that specific sections of the legal orders that individuals were subject to under AWI Act legislation had been recorded, however we found some entries that did not identify the particular section of the AWI Act that the individual was subject to. We found a few entries which simply recorded "AWIA in place". We raised this with the SCN on the day, as we considered this lack of detail and clarity could lead to confusion amongst clinical staff.

The Commission published the report *Authority to Discharge* in May 2021, where concerns had been raised about moves from hospital to care homes for people who lacked capacity, and also found there was lack of understanding by professionals around the law, including misunderstandings about power of attorney (POA).

The Commission is continuing to link in with HSCP's regarding the recommendations from the Authority to Discharge report to ensure that these are being met.

The Scottish Government provided funding to develop an Adults with Incapacity framework and learning resources for staff to access via TURAS; this continues to be progressed jointly by the Commission and NHS Education for Scotland (NES).

We will continue to keep the HSCPs and NHS Tayside appraised of this development, as this will only continue to enhance staff knowledge base when working and supporting people subject to AWI Act legislation.

Recommendation 2:
Managers should put a system in place to ensure all treatment certificates, including T2, T3 and s47 certificates are in place and that all prescribed medication is legally authorised, where appropriate.

Rights and restrictions

The door to the ward was locked and we were told that a few individuals, who due to their vulnerability and progression of their illness, would be at risk if the door was opened. Although the ward had a notice about the door being locked, it was our view that the locked door policy should be clearly displayed. Managers agreed to address this as a priority.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. No individuals had been made a specified person on the day of this visit.

Where individuals had been detained under the Mental Health Act, we found that individuals had been provided with information about their rights and had access to advocacy services which was positive. The ward had good links with advocacy service, and we were able to see involvement of advocacy services when reviewing individual files.

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.

Activity and occupation

The unit had a dedicated activity coordinator that worked 30 hours per week and provided activities either on a one-to-one or group basis. The SCN told us that the plan was to restart some of the group work and there had been discussions with the nursing staff and OT to take this forward.

We looked for evidence of activity planning in individual files to see that activities were linked to individual goals, recorded and evaluated. Although we found this noted in the care plans, we found that the recording of activities was limited and we heard from meeting individuals that they wanted to do more to keep themselves occupied.

There was no visual planner in place for individuals to know what and when activities were due to take place, however individuals did tell us about how much they enjoyed their time out of the ward with the activity coordinator. There was a folder in place that recorded activities however, there were many entries that we would not view as therapeutic activities, such as a visit from a relative, or spending time in bed. There was also no record as to the benefit to the individual.

Therapeutic activities are important to support individuals with their recovery journey and we got the impression that there may have been more activities occurring, but just not recorded.

Recommendation 3:
Managers should ensure that all activities are recorded and linked to individual care plans, with a record of the benefit of the activity to the individual.

The physical environment

Rowan Unit was a purpose-built unit that was opened in December 2011 with all accommodation in single ensuite rooms. The unit had a secure garden area that was well maintained and easily accessible. Individuals told us that they enjoyed the outdoor garden and that having their own rooms provided privacy.

The unit had an activity room, communal lounge and separate dining area and there were other seating areas throughout the unit, that offered a quieter space. There was a laundry room that enabled individuals to do their own washing whilst in hospital.

The unit has been part of the anti-ligature reduction programme occurring across NHS Tayside and we were told about some of the works that had already been carried out, with others planned for May 2024.

Summary of recommendations

Recommendation 1:
Managers should review the current MDT documentation and ensure that the record captures the MDT weekly discussion, along with the recorded actions and outcomes, including individual views about their care and treatment.

Recommendation 2:
Managers should put a system in place to ensure all treatment certificates, including T2, T3 and s47 certificates are in place and that all prescribed medication is legally authorised, where appropriate.

Recommendation 3:
Managers should ensure that all activities are recorded and linked to individual care plans, with a record of the benefit of the activity to the individual.

Service response to recommendations

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