



## **Mental Welfare Commission for Scotland**

### **Report on unannounced visit to:**

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

**Date of visit:** 9 August 2023

## **Where we visited**

Oak Tree Ward is a 20-bedded, mixed sex ward in East Lothian Community Hospital, providing care for older adults with functional mental illness, as well as those with dementia who require inpatient assessment or continuing HBCCC (hospital based complex clinical care). The ward was opened in 2019.

We last visited this service in June 2022 and made recommendations for managers to review care planning and initiate improvement work to ensure nursing care plans were person-centred, strengths-based and regularly evaluated. We also highlighted the need for medical staff to ensure that the treatment of all individuals subject to the Mental Health (Care and Treatment) (Scotland) Act 2003, (the Mental Health Act) or the Adults with Incapacity (Scotland) Act 2000 (the AWI Act), had the required legal authority in place.

On the day of this visit we wanted to follow up on the previous recommendations and to hear the experience of individuals and carers, given the continued diverse nature and wide range of needs of the individual group. We also wanted to hear from staff about how they were being supported to provide care on the ward, given the challenges reported at the last visit, of staff being “pulled elsewhere” to support other inpatient services in Lothian.

In addition, we wanted to find out on this visit if there had been progress made in the planned environmental changes on the ward; both to provide a separate wing for the care of individuals with functional illness and to address identified anti-ligature work in some individual bedrooms.

## **Who we met with**

We reviewed the care of 11 individuals, eight of whom we met with in person. We also spoke with one relative.

We met with the senior charge nurse, nursing staff, the consultant psychiatrist, occupational therapy (OT) assistant and activity co-ordinator. This was an unannounced visit and senior managers were not able to join on the day due to leave arrangements.

## **Commission visitors**

Juliet Brock, medical officer

Lesley Paterson, senior manager (practitioners)

Gillian Gibson, nursing officer

Denise McLellan, nursing officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

The ward was full on the day we visited. Four individuals were receiving care for functional mental illness, six had been admitted for dementia assessment and 10 were receiving HBCCC care for dementia.

Those who were able to speak with us gave consistently positive feedback about their experience of care. They told us nursing staff were approachable and supportive and they described feeling safe on the ward. They also described a good level of support from medical staff and said they saw their psychiatrist regularly.

The relative we spoke with said that the staff team were excellent. They were delighted with their loved one's care and described good communication from the clinical team. They also said they felt very welcome on the ward, that visiting was flexible and not restricted and they were pleased that family members were able to visit at mealtimes to assist their relative with meals in their room. They felt this was a very positive experience for both individual and family.

### **Multidisciplinary team (MDT)**

In addition to nursing and medical staff, the ward had a range of disciplines based on site or accessible to them. Occupational therapy input was provided by an OT and OT assistant and two part-time activity co-ordinators worked together to provide activity support to the ward seven days a week. The ward also had input from a music therapist once a week.

Additional support from physiotherapy, speech and language therapy and dietetics could be accessed by the team on referral.

There was no clinical psychology input to the ward. We were told that that the psychology post was still funded but, despite recruitment attempts, the post remained vacant. The grading of the post was therefore being reviewed.

We heard from senior nursing staff that recruitment and retention was not an issue and that there was only one nursing vacancy at the time of the visit. We were advised that agency staff were not utilised on the ward and that bank staff were only required to cover sickness or vacant posts. Medical staffing was more of a challenge, with a single consultant providing senior medical cover for the ward, and the specialty doctor post remaining vacant. It was hoped that, following recent interviews, the second consultant post would be filled imminently.

### **Care records**

Care records were mainly held on the electronic individual record management system TRAKcare.

In the care records we reviewed we found that daily entries were quite task orientated, with a strong focus on physical health and limited information on the person's mental state. We did not see evidence of nursing one-to-one sessions with individuals recorded. We saw notes of individual reviews by other members of the MDT, including OT.

We were pleased to note that there was some recording of individual participation in activities, an aspect which was missing during the last visit. The activity co-ordinators and OT assistant

were adding entries in individuals' records. We would recommend that this work continues to be developed and enhanced to provide further detail in these notes.

The MDT meeting notes we viewed recorded attendance, included nursing reports, and had clear action plans. We found limited evidence however of individual or carer participation, or of their views being reflected in the meeting record. The MDT records were also missing information about people's Mental Health Act status or updates regarding the authority to treat for detained individuals.

The Scottish Government produced a revised policy on 'Do not attempt cardiopulmonary resuscitation' DNACPR in 2016 (<http://www.gov.scot/Resource/0050/00504976.pdf>). This made it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or to not give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the individual. In all cases, this involvement or consultation should be recorded. We were concerned to find that some DNACPR documents were incomplete and, in many cases, did not record if a review date was required or if a legal proxy had been consulted.

**Recommendation 1:**

Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded and any requirement for review is recorded.

**Care plans**

Following the last visit, we made recommendations about improving nursing care plans and suggested that managers review care planning and initiate improvement work. The response we received from the service included an action plan for all care plans to be reviewed weekly by band 5 nurses on the ward, with monthly evaluation of all care plans by the senior charge nurse or their deputy. It was planned that the effectiveness of all interventions would be discussed and documented at the weekly multidisciplinary team meeting, with the outcome and any required changes recorded on the electronic individual record.

On this visit we were disappointed to see little evidence of improvement in the care plans we viewed. Information contained in them was somewhat basic and lacked personalisation. We found no evidence of updates or review. It was also concerning that several individuals we reviewed experienced high levels of stress and distressed behaviours, but we found no care plans to specifically address this, or to identify how staff could best support each individual in these circumstances.

Individuals who were able to discuss their care with us were not aware of their care plans and reported no participation in the care planning process.

We were advised that care plans were being audited each month and we were shown evidence of this audit; it was not clear to us however, that the quality of care plans was being audited.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

<https://www.mwcscot.org.uk/node/1203>

We are again recommending improvements in this area, similar to the two recommendations we made following our last visit.

**Recommendation 2:**

Managers must 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 3:**

Managers must 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 4:**

Managers must ensure that the regular audit of care plans includes an audit of their quality and the quality and frequency of review, to ensure that these reviews reflect the work being done with individuals towards their care goals and that the reviews are consistent across all care plans.

## **Use of mental health and incapacity legislation**

On the day of our visit, nine of the 20 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

During the visit, it became evident that the whiteboard in the staff office, which gave oversight of key details for each individual, was not up-to-date regarding the status of all detained individuals. We spoke with staff about this on the day and recommended all details were checked.

Documentation relating to the Mental Health Act was in place in all but one of the clinical records of the detained individuals we reviewed.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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 several instances where individual medications prescribed were not properly authorised by the individual's T3.

With regard to ensuring the correct legal authority was in place for medical treatment, as recommended on the last visit, the action plan from the service advised that a structured MDT meeting template had been implemented to provide a prompt to check this. A folder was also to be compiled with copies of all legal documents authorising treatment under the Act. This

was to be brought to these meetings and reviewed as part of the process. Our review of individual records did not show evidence of this process happening as planned.

We therefore repeat the following recommendation from our last visit:

**Recommendation 5:**

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

For those individuals we reviewed who had a power of attorney or welfare guardian in place, we found copies of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) documents present in their records. However, we also found a copy of a power of attorney which had not been enacted, which had created some confusion among staff as to whether the individual had a welfare proxy under the AWI Act. We spoke with staff about this and suggested careful checking and recording of the AWI Act status of each individual.

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 up-to-date section 47 certificates in place for all of those for whom this was required, with accompanying individualised treatment plans.

**Rights and restrictions**

Some of the individuals who were detained, and were able to speak with us, said that they were not aware of their rights under the Mental Health Act. They also indicated that they were unaware of advocacy. All detained individuals should be made aware of their rights, including in relation to advocacy support. We heard from senior staff that all detained individuals were referred to the local advocacy service EARS, but that the service had recently been experiencing some difficulties, and that access had sometimes been more of a challenge than previously. We suggested that advocacy support could also be further promoted, for example by using information leaflets or posters on the ward.

We asked how time out for voluntary individuals was managed, as we noticed that some individuals with functional mental illness who were admitted to the ward voluntarily had restrictions on their time allowed out of the ward; for example, having limited escorted passes. We could not find evidence in the care records of discussion with the individual or documentation of their agreement in this regard. We suggest that when such restrictions are put in place, discussions and individual agreement are clearly documented.

**Recommendation 6:**

Managers should ensure that routine practice includes that individuals are made aware of their rights when they are subject to the Mental Health Act, that there is access to advocacy support and that when restrictions are placed on individuals who are admitted voluntarily, that individual consent is sought, and this is documented in the clinical notes.

The Commission has developed [Rights in Mind](#). This pathway is designed to help staff in mental health services ensure that individuals have their human rights respected at key points in their treatment.

## **Activity and occupation**

Individuals told us that there was lots to do and always activities happening on the ward.

We were told that the OT carried out individual assessments in the ward and in people's homes, whilst the OT assistant supported the activity co-ordinators on the ward on a full-time basis. Staff were very positive about the impact of the OT and activity roles.

There was a strong focus on therapeutic interventions and the development of social skills, as well as daily living skills (such as shopping, cooking and use of public transport) for those individuals who were receiving rehabilitation and support to return home.

The music therapist visited weekly and we heard positive feedback from individuals and staff about these group (and individual) sessions.

The activity co-ordinator and OT support worker were able to provide one-to-one support, small group work and to support outings, on occasion. Recent trips had included an outing to the Museum of Flight and a bus trip to Haddington. The ward had also acquired a new seven-seater vehicle in the weeks prior to our visit and we were told of plans for outings to festival events in Edinburgh.

Most group activities were decided on the day. There was a noticeboard on the ward with the weekly activity timetable; we recommended this was kept updated to reflect the full range of activities on offer.

The OT assistant and activity coordinator we spoke with had a good knowledge of the individuals they were supporting and their specific strengths, needs and interests. When we asked about specific people who we were aware struggled to engage in group activities, the activity staff spoke about each person's specific interests and capabilities and how they successfully engaged them in activities, sometimes using specific equipment on the ward. This included use of RITA (Reminiscence Interactive Therapy Activities), of which the ward now had four machines. These mobile touch screen units enabled individuals to access music, information and activities such as games and puzzles, according to their individual interests. It could also provide calming images to support individuals at times of distress.

## **The physical environment**

The ward environment continued to look clean, fresh, and well maintained. Signage around the ward was dementia-friendly and there were further additions to the decor to promote a calming, therapeutic environment.

The large open plan living/dining space was light, bright and welcoming. As before, 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.

The ward had a spacious, well used garden area, accessed via the communal lounge. During the last visit, we were advised of plans to level a large, sloped part of the garden to improve accessibility for individuals; funding had been identified and contractors were awaited to undertake this, in addition to other improvement work planned for the garden. At the time of this visit, these works were still due to take place.

On this visit, there had been significant changes to the configuration of the bedrooms corridors, with long awaited works to adapt one part of the ward to a standalone unit, for individuals with a functional illness, having been mostly completed two months previously. This meant that there is now a separate section of the bedroom corridors, which is able to be locked-off from the rest of the ward when required. It contained four en-suite bedrooms, a small lounge area exclusively for the use of this group of patients and plans were in place to introduce a separate dining room. We were told that some individuals still preferred to use the main shared lounge on the ward, but the option was welcomed.

The four bedrooms all faced a car parking area in the hospital grounds, and we were pleased to note that decorative vinyl window screens had been introduced for privacy. We continued to have concerns about obvious risks in the bathrooms of these rooms (including potential ligature points on basin taps, toilet flushes and shower fittings). We were told that ligature risk ratings in the rooms had already been substantially reduced and that further environmental adaptations had not been deemed possible due to the nature of the new build. We were also advised of plans to review admission criteria to the ward, and it was envisaged that this was likely to reduce the level of risk in this individual group.

The other en-suite bedrooms on the ward, for those with a diagnosis of dementia, remained unchanged. We were pleased to note that people continued to be able to personalise their rooms. Some individuals had electronic calendars to help with orientation. We also noted the addition of visual prompts to indicate each person's history, interests, and needs, designed in the form of leaves on a tree on the bedroom wall.

### **Any other comments**

We heard that there were still concerns about staffing on the ward and in particular the capacity of the unit to safely manage individuals with functional illness who were acutely unwell. This was of particular concern given the isolated site and that other staff in the hospital who may be available for support in an emergency were not trained in restraint techniques.

We were told that a review was underway by senior management to re-consider the criteria for admission to the ward. This followed increasing concerns about resources of the service and the acuity of illness and level of risk that some individuals who had previously been admitted to the ward had presented. Initial proposals under consideration were that those with an acute mental illness requiring assessment would first be admitted to older adult acute wards at the Royal Edinburgh Hospital, or, for individuals who were physically unwell, that initial admission would be to the Royal Infirmary in Edinburgh. It was suggested that Oak Tree

ward would still admit those who required assessment for dementia (in addition to HBCC care) and would accept the transfer of individuals with functional mental illness who had received acute care and required a period of less acute inpatient 'step down care' prior to discharge. We look forward to hearing how these plans for the service progress.

Despite the challenges being faced by the service, all the staff we spoke with were very positive, describing a cohesive team where they felt supported by their colleagues.

On this visit, we were also pleased to hear about further developments in the community, with joint initiatives between the community mental health and care home team (the latter having been developed over the past few years) and the inpatient mental health service. These included supporting the transition of people being discharged to the community and continuing to provide stress and distressed behaviour training to care home staff. We heard that this proactive support to individuals and care home staff had continued to contribute to a significant reduction in the number of admissions to the ward.

## Summary of recommendations

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### **Recommendation 2:**

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### **Recommendation 5:**

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### **Recommendation 6:**

Managers should ensure that routine practice includes that individuals are made aware of their rights when they are subject to the Mental Health Act, that there is access to advocacy support and that when restrictions are placed on individuals who are admitted voluntarily, that individual consent is sought and this is well documented in the clinical notes.

## 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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