Mental Welfare Commission for Scotland

Report on unannounced visit to:
East Lothian Community Hospital, Oaktree Ward, Alderston Road, Haddington, East Lothian, EH41 3PF

Date of visit: 12 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Oak Tree Ward is a 20-bedded, mixed sex ward in East Lothian Community Hospital. Opened in 2019, the ward provides care for older adults with functional mental illness and those with dementia who require either inpatient assessment or continuing hospital based complex clinical care (HBCCC).

We last visited this service in August 2023 and made recommendations to improve and audit nursing care plans; to ensure the 'do not attempt cardiopulmonary resuscitation' (DNACPR) process was properly followed and recorded; to ensure all medical treatment given under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) was properly authorised and that any restrictions on individuals' rights were properly authorised and documented, supporting access to advocacy.

The response we received from the service included detailed action plans that were being implemented to address all of the recommendations.

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.

Who we met with

We reviewed the care of seven people, five of whom we met with in person. We reviewed care records for five people and met with two relatives.

We spoke with the service manager, the chief nurse and the senior charge nurse. We also met with other members of the nursing team, the activity co-ordinator and one of the volunteers.

Prior to the visit, we met with consultant psychiatrists covering the East Lothian area, in relation to recent concerns they had raised with Healthcare Improvement Scotland (HIS).

Commission visitors

Juliet Brock, medical officer

Lesley Paterson, senior manager (practitioners)

Susan Tait, nursing officer

What people told us and what we found

The ward was full on the day we visited, with eleven females and nine males.

Four people were receiving care for functional mental illness, seven had been admitted for dementia assessment and nine individuals were receiving HBCCC dementia care.

There were two delayed discharges, with one person due to be discharged imminently.

Care, treatment, support, and participation

The individuals we spoke with gave positive feedback, describing staff as “lovely” and “enthusiastic”. One person told us “the ward is very good, staff are good, patients are fine and the hospital is nice, airy and clean”.

The relatives we spoke with were highly complimentary about the staff team and the care provided on the unit. Carers told us they felt supported by staff, that communication was generally good and that they were consulted on decisions about their loved one’s care and treatment. The carers we spoke with offered no recommendations for improvements.

The interactions we observed on the visit were warm and caring. In particular, we noted a good level of support being provided at mealtimes.

Multidisciplinary team (MDT)

The MDT comprised medical and nursing staff, with occupational therapy (OT), music therapy and an activity co-ordinator.

In addition to the core MDT members, we were advised that MDT meetings were attended by a social worker from the community team and that there was also pharmacy input.

A range of disciplines were based on site, including physiotherapy, speech and language therapy and dietetics, all of which could be accessed by the team on referral. Palliative care support from specialist medical and nursing colleagues could also be accessed from a neighbouring ward.

There remained no clinical psychology input to the ward. When we spoke with managers, we were advised that there were ongoing discussions as this continued to be an area of concern but there were challenges due to the financial climate. Psychology services, hosted by Royal Edinburgh Associated Services (REAS), were experiencing widespread challenges. We were advised that psychology provision had also been raised at the NHS Lothian subgroup for older adult mental health.

Recommendation 1:
Managers should continue with their efforts to provide dedicated clinical psychology input into the ward to ensure provision of psychological therapies to the individuals in Oak Tree Ward.

We heard that although staffing felt stretched the previously, this had improved since the last visit with several newly recruited Band 5 staff nurses and now, there were only a few vacancies.

When we met with the team of consultant psychiatrists covering mental health services in East Lothian prior to the visit. Concerns were shared with us about the lack of senior medical cover across mental health services, particularly with only two of the four consultant posts in adult psychiatry covered at the time.

The consultant group had raised concerns with senior managers, the associate medical director and HIS about the impact this was having on patient safety. We were told there were ongoing meetings with senior managers to try to address ongoing challenges with actions taken in relation to recruitment and temporary locum provision.

With regard to the older adult service, two consultant psychiatrists were in post providing input to both the inpatient ward and community service and liaison psychiatry support to medical colleagues within the hospital. We were told that for some time, consultants had been advising managers that more senior medical staff were needed in the service and a business case had been put to managers to this effect.

When we met with senior managers, we were told that this was an area of review, with managers exploring options with the finance department, and looking at improving recruitment of medical staff for the wider local mental health service.

Care records
Care records were held mainly on the electronic individual record management system TRAKCare. A few documents remained on paper files, including DNACPR forms and 'Getting to Know Me' documents, which families had helped to complete.

Since our last visit, a new mental health TRAKCare record format, developed by the Royal Edinburgh Hospital, had been implemented on the ward. We were told there was ongoing quality improvement work with the staff team to improve use of the new system and to continue to improve the quality of clinical record keeping.

In the TRAKCare records we reviewed, we found that daily entries varied in quality. Some included a good level of detail about the person's mental state, engagement, activities and physical wellbeing, while others provided limited daily updates. Where canned text headings were used, these appeared to provide a helpful prompt.

Individual entries by other members of the MDT, including OT and psychiatry, provided detailed, comprehensive records of assessment and interventions.

The risk assessments we saw provided a good level of detail and were regularly reviewed.

Multidisciplinary team (MDT) meeting notes varied in quality and in the level of detail provided. A list of attendees was not always included and the record of decision- making and action plans were not always clear. The MDT meeting template included drop down menus to add details such as the person's status in relation to the Mental Health Act and treatment authorisation, where applicable, but these sections were often left blank.

We discussed these findings with service managers at the end of the visit and how record keeping could be further improved through oversight and audit.

Recommendation 2:
Managers should ensure continued improvement of record keeping using new TRAKCare mental health record system, with particular focus on improving the quality of nursing and MDT meeting records.

On the last visit we made a recommendation about auditing DNACPR forms. This was due to concerns that some DNACPR documents were incomplete and did not record whether the legal proxy or next of kin had been consulted, or whether a review date was required.

As outlined in our last visit report: The Scottish Government produced a revised policy on 'do not attempt cardiopulmonary resuscitation' (DNACPR) in 2016. 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.

At the time of this visit, DNACPR documents were in place for 14 individuals. We viewed all forms and found that several did not state a reason for the DNACPR decision, while others did not evidence consultation with the person's welfare proxy or next of kin and gave no indication of whether future review was required. This was disappointing, given that assurances were given from the service in the last action plan that practice had improved and ongoing audit was being carried out. We are therefore repeating our last recommendation.

Recommendation 3:
Managers must undertake regular audit of all DNACPR forms to ensure that these are completed fully, that any requirement for review is recorded, and where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

Care plans
We were pleased to see that the service had begun using the new electronic mental health care plan format, which had been introduced in the Royal Edinburgh Hospital, with a view to this being adopted in mental health services across NHS Lothian.

The care plans we viewed were of variable quality. In our view the stress and distress care plans we saw needed more detail and did not describe the interventions required for staff to best support each individual.

We saw some evidence of participation in the care planning process from individuals who were able to contribute to their care plan, or from family members. It was evident that many individuals on the ward would not be able to participate in the care planning process, so the involvement of carers where possible would be good practice.

Care plans reviews were also variable, with some reviewed every two to four weeks while others had not been reviewed for almost a year. Monthly care plan audits by senior nursing staff were being undertaken.

The Commission has made several recommendations for the improvement of care plans following our last two visits. Although comprehensive action plans have been provided by the service, with plans in place for regular audit and for the effectiveness of interventions to be discussed and documented at weekly MDT meetings, this did not appear to have translated to effective improvement. We are therefore repeating the recommendations around the need to improve the care planning process.

Recommendation 4:
Managers must ensure that 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 5:
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.

In discussion with senior managers, it was acknowledged that care planning was an area for ongoing improvement, particularly optimising the use of the new care plan

format. We were pleased to hear that staff were due to attend a webinar on care planning a few months after our visit. We look forward to seeing improvement at this time.

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.

Use of mental health and incapacity legislation

On the day of the visit, 14 of the 20 individuals in the ward were detained under the Mental Health Act and the relevant documentation was in place in the clinical records 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. In most cases, consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required. However, one person had no T2 or T3 in place and had been treated without legal authority for several months. We discussed this with senior staff on the day. We also notified the team of several individuals whose prescribed medication included treatment that was not properly authorised by their T3.

Although the previous two action plans from the service indicated that the authorisation of medical treatment had improved through regular review at MDT meetings and with audits being carried out, we did not find evidence of this. We discussed this ongoing concern with senior managers on the visit and are repeating the recommendation from our previous two visits.

Recommendation 6:
Medical staff and managers must ensure the required legal authority for treatment is in place for all individuals who are subject to the Mental Health Act or Adults with Incapacity (Scotland) Act, 2000 (the 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. A robust audit should be introduced to monitor compliance with this.

The individuals we reviewed who had a power of attorney or welfare guardian in place had copies of the relevant AWI Act documents present in their records.

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, with accompanying individualised treatment plans, in the files we reviewed.

Five individuals were receiving covert medication. We could find covert medication pathways in place for only four of these people, and three were overdue for review.

Again, we raised this with senior staff at the end of the visit and highlighted this as an area requiring improvement.

Recommendation 7:
Managers must ensure that when covert medication is in place, covert medication pathways are completed and are reviewed timeously.

The Commission has produced good practice guidance on the use of covert medication.[1]

Rights and restrictions

The ward had restricted entry and exit for the safety of those receiving care. A locked door policy was in place and explanatory information was displayed at the entrance.

The ward had good advocacy support from the local EARS advocacy service and individuals we spoke with were aware of access to advocacy.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied.

Specified person restrictions were in place for one individual, but we were unable to find evidence that their status had been reviewed or updated for over one year. We discussed this concern with senior staff on the visit; we suggested that those subject to specified persons regulations could be highlighted on the clinical noticeboard in the ward office, to act as a prompt for review.

Recommendation 8:
Managers should monitor the use of specified persons restrictions and ensure that appropriate reviews are carried out as required. Managers should also consider MDT training in the application and use of specified persons.

The Commission has produced good practice guidance on specified persons[2] and developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health

[1] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492
[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

There was a good range of activities available on the ward, and we found there was a thoughtful and personalised approach taken to how best to engage each person.

The OT focussed mainly on carrying out individual assessments and supporting those who were returning to the community with the daily living skills they required, while the OT assistant supported the activity co-ordinator to provide a programme of individual and group activities.

We were told that activity co-ordinator provision had been halved to one full-time post and that funding had had an impact on what the service was able to provide. There was no longer activity co-ordinator support seven days a week.

Art psychotherapy input was usually provided by a music therapist; however, weekly music therapy sessions were not available at the time of our visit. We heard that the absence of weekly visits by the music therapist was a loss, as people on the ward had engaged very positively with both individual and group sessions. It was hoped by the team that music therapy would soon resume.

Despite these limitations, feedback about activity provision remained generally positive. Four volunteers from the hospital volunteering service were providing additional support to the ward, which was helping to fill gaps in provision. Volunteer roles included reading to individuals and helping with small group activities. This input was welcomed by both the individuals and staff we spoke with.

The physical environment

The ward was clean and well maintained. There was dementia-friendly signage around the corridors, as well as artworks and items of visual interest.

The large open plan living/dining space was light, bright and welcoming. Decorated in a calming green, with comfortable sofas and armchairs and pictures on the walls, the lounge area offered a comfortable and relaxing communal space.

In the corridors, there were additional spaces for relaxation, including the reception area with a fireplace and comfortable sofas, as well as armchair seating in one of the bedroom corridors.

There was an activity room (adapted from a former bedroom) where the activity co-ordinator ran sessions and groups. An activity board near the reception area provided a timetable of activity sessions and photos on the walls showed people participating in some of the recent outings and activities. We heard that the ward had just acquired a projector and planned to use one of the rooms as a mini cinema.

Further recreational spaces around the ward included a hair and beauty salon (which staff had equipped through fundraising) offering individuals hairdressing by a staff member who was a trained hairdresser, 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. There had been plans underway for several years to level a large, sloped area of the garden to improve accessibility. On the last visit, funding had been identified and contractors were awaited to undertake this job. We were told on this visit that plans to level the slope had not proved possible, however other improvement works were planned for the outdoor space, including the introduction of more seating, planting and a shaded area. This work was out to tender and it was anticipated that it would be completed by the year end.

There were three main bedroom corridors on the ward, with one section which had been developed over recent years as a separate area for those with functional mental illness. This was able to be locked off from the rest of the ward when required.

All rooms were clean, suitably furnished, able to be personalised and had en-suite showers. There were boxes outside doors to help those with a diagnosis of dementia to add personal object or photographs to help them identify their room. We also noted that inside each room, there was good use of a tree design on the wall, with visual information in the form of leaves to indicate the person's history, interests, and needs, with relatives able to add information and photographs. This provided a helpful prompt for conversation and to highlight the person's individual needs.

Summary of recommendations

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Recommendation 2:
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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 an individual's care, treatment, and support are 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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