

Report from our visits to people admitted to adult acute mental health wards

Report from our visits to people
in receiving mental health care
and treatment in Scotland
January – May 2010

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Who we are and what we do

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should

- Be treated with dignity and respect.
- Have the right to treatment that is allowed by law and fully meets professional standards.
- Have the right to live free from abuse, neglect or discrimination.
- Get the care and treatment that best suits his or her needs.
- Be enabled to lead as fulfilling a life as possible

Our work

- We find out whether individual treatment is in line with the law and practices that we know work well.
- Challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Our visits

One of the ways in which we monitor individual care and treatment is through our visits programme.

We visit people in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered. As part of our visits programme we visit people in hospital.

This report reflects our findings from a programme of national themed visits to adult acute mental health wards. The aim of national themed visits is to enable us to assess and compare care and treatment for particular groups of people across Scotland. Our aim is to help services learn from good practice and to respond to any issues that are identified. This report provides an overview of our findings from a series of visits that took place across Scotland between January and May 2010.

Why we visited

We regularly visit mental health adult acute wards. By visiting all such wards across Scotland within a short period of time, we are able to compare and contrast care and treatment available in different hospitals and how issues of patients' rights are managed throughout the country.

During our visits we asked people about their time in hospital. We are interested to hear if individuals feel they are being treated with respect and dignity in places where they can feel safe. These are issues which have been brought to the attention of our visitors in the past.

We also asked people, where appropriate, about their views of enhanced observation and their experience of being closely monitored by staff. This is an area of clinical care where we are interested to see if the principles of the Act are being applied and individual rights are being protected

We looked at restrictions placed upon individuals and whether or not the 2003 Act is being applied in a uniform way. We also looked at how people were being involved in their care and treatment and how they were supported to make informed decisions.

How we carried out the visits

Between January and May 2010, we visited all of the adult acute mental health wards across Scotland; we met with a total of 258 people receiving care in 57 wards across 28 sites. Appendix 1 provides a list of wards we visited.

Our visits were announced in advance so that people who had particular concerns could arrange to meet with us. We also asked people we met on the day if they would be willing to share their experiences with us by answering some prepared questions. Most people did not answer all of the questions, responding to those that were most relevant or interesting to them. ***Percentages included in this report are based on total responses to each particular question.***

We asked a member of staff in each of the wards a series of questions about the people currently in the ward and about how their care and treatment was provided. Where possible we met with relatives and carers who happened to be in the ward at the time, or had requested a meeting with us.

We also examined case notes in each ward to look at the care being delivered and how this is recorded.

By looking at different sources of information we were able to get a broad picture of care in the wards we visited. Our observations and what people told us form the basis of the findings in this report.

Introduction

On the whole, those we met with during the visits were generally satisfied with their care and treatment. People felt they were treated with dignity and respect and the majority felt safe in the wards. Staff were reported to be approachable. The level of participation in care was generally high. And many older wards have been replaced with modern facilities, often with single room en-suite accommodation, with more planned for the future.

Key messages

In this report, we give details of good practice and of widespread positive responses from individuals about their care and treatment. Many of the responses showed that people's experiences had improved since our previous visits. For example

- The creation of female only sitting rooms
- Wide availability of advocacy services.
- Where requested, doctors interviewing people prior to and after reviews rather than being asked to attend a large meeting.
- Discharge planning commenced at an early stage.
- Increase in provision of written information

And as one person commented

I appreciate the manner and approach of my psychiatrist. He takes an holistic interest - not just administering drugs. He really seems interested in me as a person and is not at all authoritarian - something I experienced elsewhere. (Royal Cornhill Hospital)

Based on what we found on our visits, we have chosen to highlight in the following particular aspects of care and treatment where we would like to see change and improvement. These key messages should be considered together with the recommendations for action needed within each of the subsections of the report.

- **Whilst the majority of people felt they were treated in general with dignity and respect, we found it was quite common for people to have to wait in a queue to receive medication. In our view, this does not afford confidentiality or dignity to the individual and ward managers should change this outdated practice.**
- **When people's rights to liberty, privacy, dignity or respect for family life are restricted, then it must be lawful and proportionate. Managers need to ensure that staff understand the correct legal procedures for preventing people from leaving hospital and imposing other restrictions on them.**
- **While most people feel safe, a significant number of people, especially women, continue to feel unsafe in adult acute wards. Many of those who report their concerns to staff are not confident that these are properly dealt with and commonly do not receive feedback about the outcome. Ward managers should ensure that people who express concerns about their safety get support and feedback on what staff have done to address their concerns.**
- **We found that the level of training and awareness in observation practice in many wards was insufficient to enable staff to comply with national guidelines. Almost half of the 54 staff interviewed had not received training in observation practice. Managers should introduce training in therapeutic observation for all participating staff**

- **A significant number of wards did not have a process to formally review observation levels on a daily basis including weekends. Doctors and nurses should agree a procedure for the delegation of authority to review observation levels so that any unnecessary restriction can be minimised.**
- **Many people reported that they were not given sufficient information about their care and treatment. Managers should ensure that a record is kept of when information is given and whether the person has understood the content.**
- **A significant number of people we visited felt that they did not meet their named nurse often enough, and many did not know who their named nurse was. There was also a lack of feeling of involvement by individuals in their care and treatment. Ward managers should review the named nurse system and ensure individuals have the opportunity to participate in their care.**
- **Although we found evidence of discharge planning in almost all of the wards visited, many individuals were unaware of their plans for discharge. Doctors and ward managers should consider giving written as well as verbal confirmation of discharge plans to people in their care.**

Privacy and dignity

Whilst the majority of people felt they were treated in general with dignity and respect, we found it was quite common for people to have to wait in a queue to receive medication. In our view, this does not afford confidentiality or dignity to the individual and ward managers should change this outdated practice.

What we expect to find

*'Mental Health nurses....need to embrace models of practice and new ways of working that focus on meeting the rights and needs of people, maximise therapeutic contact and promote recovery based working in line with the shifting focus of health care detailed in *Delivering for Health*'.*
(Scottish Executive, 2006, p20)

We would expect to find a staff culture that promotes recovery and a therapeutic environment, where people have access to the level of support and assistance they need. Individuals should be kept informed about regular, planned sessions with their key worker. The content of discussion should be documented in the individual's case record and, where appropriate, feedback given to the individual on action that will be taken. Medication needs to be administered in a supportive and individualised way, affording privacy and confidentiality to the individual.

What we found

In all wards visited, we asked individuals a range of questions about how they felt they were treated in general. We also asked specific questions about their views on their medication, whether they have a quiet place to go and somewhere to keep their possessions safe and private.

Of the 193 responses from individuals about how they felt they were treated in general, the majority (64%) were positive, 23% had mixed comments and 13% were unhappy. Examples of positive comments were

“Brilliant. I get on great with all the staff. They are very polite with everyone. They treat you with manners. They take you seriously and don't look down on you.”

“Staff are generally nice and talk to you about your problems and see how you are feeling. We go to various groups and discuss things there with staff.”

From the adverse comments received, lack of individual contact with staff was a common theme:

- There was a shortage of time to speak to nurses on a one to one basis
- Nurses were often busy with paperwork and commonly said 'I will see you later'
- People experienced delays in seeing a doctor when they reported feeling physically unwell

In two cases individuals felt they got more attention from night staff:

“I need more 1:1 therapeutic time with nursing staff” (Individual reported that night staff tended to spend time with her if she needed it.)

“I would like more personal time from staff.” (Again the individual felt that night staff had more time, but day staff spent much of their time on observations or doing paperwork in the office.)

Sadly, for a small minority of people, these experiences are very similar to some of those reported in our previous reports of unannounced visits to adult acute wards. (MWC, 2005, MWC 2009).

- **Private space**

Of the 205 responses we received about whether there was somewhere private to meet visitors, 84% (172) responded positively, while 11% (22) felt there was no suitable private place to meet. For individuals with single room accommodation, finding alternative space to meet with visitors was less of an issue than it was for others. Although only a small number of individuals commented on the lack of suitable space, we thought this was an issue as a large number of wards we visited had no designated room.

“Visitors are seen in the day room as a rule”

“Three rooms all have TVs in them. Often people are using them so it is difficult to ensure a quiet area to meet with family”.

When we asked about somewhere quiet to go it was clear that, where single room accommodation is not available, it is difficult to find any private space.

“I have my own room. Other than my bedroom, I can go to TV room”

One person we visited said that the sitting room only had enough seats for half the number of people on the ward. There was a quiet room but it was uncomfortable with only two seats. She rarely used the space.

- **Keeping possessions safe**

The majority of individuals (83%) said that they felt able to keep their possessions safe and private. Many commented that they handed their valuables in to nursing staff for safe keeping and appeared to be satisfied with this arrangement. However for some this arrangement was not satisfactory as it involved having to seek staff out to access the office safe.

"The safe beside the bed does not lock. They have not got keys. We can leave our valuables in a safe in the office. I just wear my jewellery".

Mr G described sleeping with his valuables under his pillow: wallet, jacket and also CD player. He felt that the small safe in the bedroom was not functional, it did not lock and no keys were available. The individual was aware his valuables could be stored in the office safe, but he would like valuables locked in his bedroom.

- **Medication administration**

Of the 195 responses we received relating to dispensing medication in a dignified way, 84% were positive suggesting that people are comfortable in relation to the way medication is dispensed. However, we found it was quite common for people to queue to receive medication. In our view this is an outdated practice and does not afford confidentiality and dignity to the individual. The following comments illustrate how some patients feel about being treated in this way.

There is a "big queue" for the medications. "One nurse reads out ...and one hands over the medication".

"Other people can hear what medications you are getting".

"It does not bother me, but others might be bothered".

"I found it hard when I first came in. You have to queue. Usually not long but I am used to it now".

This type of practice is designed to suit the needs of the service rather than the individuals receiving treatment and is an outmoded approach in modern mental health care.

Good Practice Example

One individual described a system where nurses go individually to find each patient when it is time for medication. This demonstrates an individual approach sensitive to people's needs and issues of confidentiality.

Action needed

- People value the therapeutic relationship with nurses where it is based on partnership and mutual respect. In order to promote a recovery based approach, regular and protected time with nurses should be the norm, not an aspiration.
- Acute wards must provide safe and appropriate ways of administering medication to ensure that individuals are treated with dignity and their privacy respected.
- Individuals should have access to a quiet space that affords privacy for them and their visitors.
- Provision should be made in bedroom areas to enable individuals to store their valuables safely without the need to constantly ask staff for access.

Rights, risks and restrictions

When people's rights to liberty, privacy, dignity or respect for family life are restricted, then it must be lawful and proportionate. Managers need to ensure that staff understand the correct legal procedures for preventing people from leaving hospital and imposing other restrictions on them.

The articles of the European Convention for Human Rights were incorporated into Scottish Law in 1998. The Mental Health (Care and Treatment)(Scotland) Act 2003 has procedures and safeguards that protect people's human rights. In particular, the 2003 Act has procedures for lawfully detaining people. To detain someone in hospital without using the proper procedures may be a breach of the person's human rights. Also, searching people or restricting their ability to communicate with whoever they choose can breach the person's right to privacy, dignity and respect for family life. The 2003 Act has procedures in place to make sure that any interference is lawful and does not restrict the person's freedom any more than is necessary.

What we would expect to find

Staff working in adult acute wards should have knowledge and awareness of mental health legislation and of the legal and human rights of individuals whether subject to detention or not. Individuals who have their freedom restricted in terms of, for example, access to the telephone, being searched or required to give urine samples should be given an adequate explanation as to why this has been done, the right to refuse where appropriate and also, where subject to legislation, information about any right of appeal. Where necessary, nurses' power to detain should be used as intended and unlawful or '*de facto*' detention avoided.

What we found

- **Access to telephones**

The overwhelming majority (93%) of individuals described having access to a telephone. This is a major improvement from our unannounced visits to acute wards in 2005. However, the degree of privacy afforded when using the public telephone remains an issue for a number of people. The increase in use of mobile phones has helped. However, visitors found that in many wards there were restrictions placed on the use of mobile phones within wards or at certain times of day.

"There is a lack of privacy and the public phone does not receive incoming calls" (According to one member of staff the ringing was disturbing people trying to sleep at night).

"The public phone does not accept incoming calls. That makes it difficult for me, you need lots of change to ring out and nobody can ring in to speak to me".

He has his own mobile phone on which he receives incoming calls. When he requires privacy to phone his parents or sister.....he is given access to the phone in the ward manager's room.

"I use the Pay-phone or nurses can let you use the staff phone. Mobiles can only be used in reception area".

When people are in hospital, and in many cases detained against their will, the telephone may be their main source of contact with friends and family, especially when they live some distance

away. Unnecessary restrictions on access to this form of communication can deprive people of their main social supports.

We have heard of concerns about mobile phones that take pictures. This can infringe people's right to privacy. Some wards have found a way round this by holding a stock of basic mobile phones that will take SIM cards but do not take pictures. We think this is a good solution to the problem.

- **Searches**

Around a half (108) of all people interviewed had had their possessions searched. Some did not distinguish between nurses compiling an inventory of their belongings on admission and requests for a search at a later date.

97 (82%) of 119 who responded agreed to have their possessions searched. 15 (12%) did not agree.. Individual responses are illustrated as follows:

"I gave the nurses permission to check my belongings. I think they were looking for items I could hurt myself with. They were also checking my things in".

"the nurses looked at my belongings when I came into hospital. I think it's to keep me safe".

MWC visitors also noted:

When he first arrived following a self harming incident, Mr D's possessions were searched. He states that he was provided with an explanation which he found acceptable.

On admission, as standard procedure, and on occasions when he has been out of hospital - he admitted he brought back alcohol (and possibly illicit drugs).

Some individuals did not appear to be fully aware of their rights with regard to having their belongings searched. Whilst nurses have a duty of care to individuals in the ward, unless there is an immediate risk to someone, consent must be obtained for the search. Where people are being searched on a regular basis and are detained, they should be made a "Specified Person" under Section 286 of the Mental Health (Scotland) Act (2003).

- **Requests for samples**

During the current admission, 39% of 209 respondents were asked to provide a random urine sample. 73 agreed to this but 11 (12%) did not. However, in one case a visitor noted:

Staff advised that she sometimes agrees to random urine samples and at other times refuses. However, there was no "specified person" documentation in the file.

Whilst 12% of respondents had not agreed to either searches or samples, only 5% of respondents had been made 'specified persons' under the Mental Health (Care and Treatment)(Scotland) Act 2003. This implies that a number of people may have been deprived of their rights afforded by the "Safety and Security" aspects of the legislation.

According to the 2003 Act, where a person's responsible medical officer (RMO) decides that restrictions should be applied to use of telephones, searches or samples, they must first designate him/her as a specified person. The regulations state that the RMO must, within the six months prior to any restriction being implemented, have recorded a "reasoned opinion" that without

restrictions being in place there would be a risk to the individual or to others. Being made a "Specified Person" does carry with it the right of appeal.

Further information on this can be found in our Specified Persons good practice guidance (MWC, 2010).

- **Freedom of movement**

Fifty nine per cent of people stated they had freedom to leave the ward when they chose. 41% said they did not. People did not always appear to understand their right to freedom of movement when admitted on a voluntary basis. Locked doors, even where there is a keypad entry, inhibit individuals' ability to go outside, especially when this may require the consent of a member of staff. Some of the comments given by people in hospital on a voluntary basis reflected this lack of clarity.

"I have to ask [to go out]...the doors are locked, front door and between the units. There is a keypad - but I don't know the code".

"I have unlimited passes now. The doctor recommended I did not leave the ward but it wasn't clear that I could go anyway".

In some wards, however, access to a secure courtyard garden allows people to go outside and get fresh air without leaving the ward. This provision, together with the slow release door opening facility found in some hospitals are examples of good practice in balancing security with freedom of movement.

"De facto" detention

Where individuals meet the criteria for compulsory treatment in hospital, they should be given the full safeguards provided by treatment under the 2003 Act. If the RMO considers that compulsion may not be necessary and wishes to avoid the use of the mental health act, but is still concerned that the individual may not always comply, then a written plan should be in place detailing what should happen if the person expresses the wish to leave the ward. Unless an appropriately qualified nurse feels that the patient meets the criteria for the use of the nurse's holding power, an informal patient who wishes to leave the ward has that right (Short term detention monitoring report, MWC 2010).

Seventy five per cent of nurses interviewed were aware of the provisions of s291 of the MHA regarding unlawful or "de facto" detention.

Nearly all (93%) of nurses had come across the phrase "detainable if trying to leave the ward". This topic provoked the biggest reaction from nursing staff

"My biggest gripe" We are forever highlighting this to medical staff, but they still use it.

"(people) were not aware this comment had been written in their notes."

"I don't like it at all. Medical staff have a bad habit of writing it in notes. It's leaving nursing staff wide open. It's not clear how nurses are meant to act".

"One of the consultants is known to do this and has been asked not to. If this is written in notes, then staff feel it is difficult for an out of hours junior doctor to go against this if called to attend."

Some good examples were also found where the record specified that the individual should be reassessed if wanting to leave the ward and that the nurses' holding power may be required. However, we found statements in 25 individual case files that contained the phrase "informal but detainable if tries to leave" in notes regarding the need for EDC and STDC

One visitor noted that

The duty doctor who admitted him stated he would be detained if he tried to leave.

And one person reported

Staff were trying not to use detention for my own sake. I came in informally then changed my mind but I knew if I tried to leave they would detain me.

In another case, the person was satisfied with how the issue of possible detention had been handled:

...said she tried to leave a couple of times during nights, when she was ill. She was seen by a doctor on each of these occasions who had explained ("not threatened") that she might be detained for her own safety. She stated she thought this was "fair enough".

Twenty-two per cent of individuals asked said that they had been told they would be detained if they tried to leave the ward. A significant number of people recalled occasions when they had been informed that detention in hospital would be applied if they tried to leave. However, few were aware of the provisions within the law for appeal against unlawful detention. Most people reported that they felt they had to acquiesce with this suggestion for fear of being detained on a compulsory basis. Where there is a locked door, this feeling of lack of choice appeared to be further enhanced.

The statement "detainable if wishes to leave the ward" is not acceptable. It increases the risk of a person's rights being overlooked such that they become "de facto" detained (detained with no legal authority and without the safeguards of the law).

- **Nurses' power to detain**

According to Section 299 of the Mental Health (Care and Treatment)(Scotland) Act 2003, nurses of the prescribed class (RMN) may detain a person in hospital for a period of up to 2 hours so that arrangements can be made for a medical examination to be carried out. The person can be held for a further period of up to 1 hour after the medical practitioner arrives. We looked at how this part of the legislation is being implemented.

Where nurses considered that someone should be assessed for detention, only 40% of nurses interviewed had ever used the nurses' power to detain/nurses holding power. A similar percentage stated that they were unaware of the nurses' holding power having been used in the ward in the previous year. Nursing staff who were interviewed appeared to see the nurses' holding power as somehow unnecessary and typically said they were always able to persuade someone to stay in order to be examined by a doctor.

Where an individual was asked to wait to see a doctor, locked doors or nurse "sentries" on the door were perceived as a further barrier to leaving. Our Annual Monitoring Reports show a wide variation in the use of this part of the 2003 Act across Scotland and this appears to reflect differing interpretations of the need for its use. The nurses' holding power defines the time limits of the request by nursing staff to authorise someone to be assessed by a doctor. In areas where this

measure is never used, there may be instances where people can be kept waiting without limit of time and unaware that this can be challenged under Section 291 of the Act.

Action needed

- Services should develop a procedure to allow people to make telephone calls in private and include guidance on the use of mobile phones which balances telephone access and need for confidentiality.
- Where people are detained and searches are being carried out on a regular basis, the use of compulsory measures around safety and security within mental health act legislation is a more appropriate way to ensure peoples' rights. Requests for the giving of samples of urine are subject to similar requirements. We have noted that safety and security measures are being underused in some areas and applied in a "blanket" way in others. Service managers should audit their practice in this area.
- Ward managers should review door access to ensure that use of keypads or staff "sentries" are not inhibiting people's freedom of movement other than where this has been planned and agreed and is consistent with the law. There should be a clear protocol in place for when the door to the ward is locked and monitoring put in place to ensure this only happens for the shortest time required.
- Doctors should stop the practice of describing an individual as "detainable". This decision can only be based on an assessment at any one time. Further review will be necessary before any decision regarding detention under the MHS Act can be made at a future date.
- Senior nurses should review the use of nurses' holding power within their area of responsibility and audit not only situations where it has been used, but also where it is not being used and perhaps should be.

Safety

While most people feel safe, a significant number of people, especially women, continue to report feeling unsafe in adult acute wards. Many of those who report their concerns to staff, however, are not confident that these are properly dealt with and commonly do not receive feedback about the outcome. Ward managers should ensure that people who express concerns about their safety get support and feedback on what staff have done to address their concerns.

What we would expect to find

We would expect to find a staff culture that promotes safety and supports a therapeutic environment where people have access to the level of support and assistance they need.

What we found

- **Feeling safe**

Of the 225 people who responded to questions about feeling safe, the majority reported positively: 80% felt safe during the day and 90% during the night.

Eighteen per cent of people said they have not felt safe since their admission and/or they do not feel safe during the night. This is similar to our findings in the unannounced visits to adult acute wards in 2005. (MWC, 2005)

Half of those who said they have felt unsafe said they had reported these feelings to staff. Of those who reported their feelings, half thought the staff had responded appropriately. There were also 20 people who felt that the ward was not a safe place for their visitors.

One patient who was particularly concerned about staffing levels advised:

"I reported this to staff, but they were unable to give me time for discussion".

When we discussed the issue of safety with staff, of the 57 staff members interviewed, over a fifth did not know what to do if someone reported feeling unsafe.

Of those people who reported feeling unsafe, a disproportionate number, about two thirds, were female. This is similar to the proportion found in our unannounced visits to acute wards in 2005 and suggests there has been little improvement in this area. A common theme from people visited was that staff either didn't take their concerns seriously, or they didn't have time to spend discussing the issues. One person said

"I have talked to many of the nurses about feeling unsafe at times in hospital. I don't think children should visit places like this."

Some of the women said that they had reported feeling unsafe to staff. On one ward where a man was described by an individual as sexually intimidating and verbally aggressive, the response from staff was perceived not to have made any difference.

"I have approached staff but they don't seem to have done anything about it".

"I would talk to my named nurse but that can be a waste of time".

"I did not feel safe when incidents were ongoing and had nobody to discuss this with. I felt particularly vulnerable at night".

It is clear from comments that many who reported concerns to staff did not feel that they were able to discuss matters with staff, and many did not receive satisfactory feedback about how matters had been dealt with.

Action needed

- Adult acute hospital wards should provide an environment that helps people feel safe, with access to staff who are both visible and available to offer and provide support.
- Particular attention should be given to ensuring people feel safe, especially in environments that cannot offer single sex accommodation.
- Where concerns about safety are raised, these should be fully investigated and information shared with the person about any outcomes/actions taken.

Observation

- **We found that the level of training and awareness in observation practice in many wards was insufficient to enable staff to comply with national guidelines. Almost half of the 54 staff interviewed had not received training in observation practice. Managers should introduce training in therapeutic observation for all participating staff.**
- **A significant number of wards did not have a process to formally review observation levels on a daily basis including weekends. Doctors and nurses should agree a procedure for the delegation of authority to review observation levels so that any unnecessary restriction can be minimised.**

Observation is a process that ensures close monitoring of, and therapeutic engagement with, someone who needs (for a period of time) intensive care and support. It is a formal, structured process and, therefore, is fundamentally different from the normal monitoring of patients within a ward or care setting. (CRAG, 2002)

Enhanced observation is intended to be a process of therapeutic engagement put in place to ensure the safety of individuals assessed as being at risk. Over a prolonged period of time, this can be experienced as an intense, intrusive and disempowering experience for the recipient. It may even infringe on their human rights.

Observation policies and procedures play a part in providing guidance in caring for people during periods of increased distress. The process of observation, in order to fulfil its objective, must be both safe *and* therapeutic. People who need this level of support require safety, compassion, understanding and appropriate treatment. To achieve this, individuals must be engaged in a positive and therapeutic relationship with staff and this relationship needs to continue after observation levels are reduced.

What we would expect to find

All wards should have a local observation policy developed in line with the CRAG “Engaging People” guidelines. Staff carrying out these duties should be appropriately trained and the practice of observation should respect individuals’ rights and accord with the principles of the Mental Health (Care and Treatment)(Scotland) Act 2003.

What we found

During our visits, we talked to 81 people who were either currently subject to enhanced levels of observation or who had been at some point during their current period in hospital.

- **Policy/training**

“All staff who undertake observation should be specifically trained to do so, understand the importance of the duty they are carrying out and have the skills to deliver brief psychological and practical interventions to benefit the patient”. (CRAG, 2002)

Almost all hospitals (91%) we visited had a local observation policy. However, of the 57 staff interviewed, only 32 (56%) had access to the CRAG “Engaging People” national guidelines on observation. A similar percentage (54%) of staff said they had undertaken some form of training in observation practice. In most health board areas, however, staff are simply made aware of the local observation policy, and expected to familiarise themselves with it, as part of their initial induction. This would appear to indicate a significant shortfall in meeting training needs identified by CRAG.

- **Levels of observation**

The “timed check” form of observation is seen by the group as unsafe and should not be used as a means of meeting a need for an increased level of observation. (CRAG, 2002)

According to the “Safety First” (5-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2001), the risks inherent within “timed checks” outweigh the possible benefits. When someone is assessed as being at risk, checking on their whereabouts at regular intervals is neither effective in managing risk nor therapeutic as a form of engagement. Being aware of the patient’s whereabouts supports good nursing practice but should not be considered a part of the observation process.

The three observation levels recommended by CRAG are used by around two thirds of hospitals.

These are

- General** The staff on duty should have knowledge of the patients’ general whereabouts at all times, whether in or out of the ward.
- Constant** The staff member should be constantly aware of the precise whereabouts of the patient through visual observation or hearing.
- Special** The patient should be in sight and within arm’s reach of a member of staff at all times and in all circumstances. (CRAG, 2002, p2)

However, some form of “intermittent” or “timed” checking still in use in a small number of wards as a form of observation. As one nurse commented

“(we use) interval observation - every 10 minutes. Medical staff have a problem with moving away from this.”

Where it is used, it is seen as a form of “stepdown” from a period of enhanced observation. This practice goes against the recommendation in CRAG. Intermittent checking should not be viewed as observation and should not be recorded as such.

- **How enhanced observation was explained**

Observation is an intervention which generally takes place when a person has been assessed as being at risk to themselves or others and an explanation given by staff might not always be retained. Two thirds (54) of the 81 people subject to observation stated that they had been given an explanation. One third (27) said either they had not been given an explanation or that they didn’t know whether they had or not. MWC visitors commented

He was able to clearly state why he was on a higher level of observation, describing the observation level as being something that could “keep him safe”.

She had been on constant observation on two occasions. She understood the observation level was raised because she had "self harmed". She also understood that she was "being kept safe by staff".

However, in some cases people were not informed and had to infer reasons for enhanced observation. One visitor noted

No explanation had been given. She believes it was due to self harm risk.

CRAG recommends that written information should be provided to all people subject to increased observation. This would facilitate an understanding of the reasons for this and supplement the verbal discussion where this occurs.

- **Review of observation level**

The purpose of observation is to 'provide a period of safety, during temporary periods of distress with observation levels set at the least restrictive level, for the least amount of time, in the least restrictive setting'.(CRAG, 2002)

Eleven of the 53 wards did not carry out a formal review of observation on a daily basis. This was reported to be due to the demands placed on medical staff working both in wards and community or only being available in the ward during part of the week. In one ward, the nurse was

..keen to introduce nurse led reduction (in observation level) as staff feel patients are often on higher level of observation for too long. The RMO will not review daily and junior doctors are reluctant to reduce.

As we did not meet with medical staff on the visits, it is difficult to know where the obstacles to a change in policy might lie. Alteration to the level of observation, however, should ideally be a team decision. But, in order to ensure individuals are not left on an enhanced observation level inappropriately, teams can plan ahead, particularly at weekends, clarifying the circumstances that would enable a reduction in observation level to take place. As part of this process there should be a clear local policy clarifying the authority of the nurse in charge to reduce observation levels.

Some people may be kept on a high level of observation for longer than necessary if nobody is available to review the need for it. This can be an unnecessary restriction of privacy and freedom.

Good Practice example

One Staff Nurse described a system that allowed nursing staff to reduce observation level from Constant to General. Following discussion with the RMO, risk behaviour is identified and agreed. If risk behaviour reduces or stops, the nursing staff can reduce observation level without reference to the RMO. This approach is also used with patients who may be admitted whilst intoxicated with drugs/ alcohol. (Carseview Centre)

- **Attitude of staff**

The vast majority of patients said that staff had a helpful attitude towards them at this time. MWC visitors commented

Mr T was on constant level of observation when first admitted to Ward. He states that he was treated with kindness and respect and that staff spent lots of time talking to him.

She liked being on observation as it made her feel safer (from herself). She also found it easier to interact with staff when on observation.

However, not everyone had such a positive experience. One person felt that

“ Staff can look very bored at times - reading magazines, playing on phones etc. It would be helpful if staff introduced themselves at hand-over times and made an effort to talk or ask 'would you like to talk or be left alone'”.

One visitor heard from an individual that there were

...too many staff involved. Some talk with her, engage with her, or sit in the room, quiet but with her. Others sit at the door, back to her, talking with colleagues about their family or what they did at the weekend.

Clearly, training, supervision and leadership are required to promote a consistent approach to observation to maintain a therapeutic rather than task oriented approach.

Mental health inpatient care is an area of practice where the ability to deliver care and services based on the rights-based principles of the MH(S)A may be particularly tested and challenged. It is also an area in which mental health nurses sometimes feel compromised in their ability to deliver rights, principles and recovery-focused care. Challenging the mind set of health professionals and influencing culture is key. (NHS NES, 2007)

Training and supervision of staff are fundamental to promoting a caring and therapeutic approach to observation. Feedback from individuals of their experience of this type of intervention can also help staff understand the experience from the recipient's viewpoint and contribute to changes in practice.

- **Respect for privacy**

Almost all of the people were satisfied with the degree of privacy offered for intimate self care. One person interviewed

.... dislikes being on observation. That said, she understood why she was on it, staff were professional and she felt she was on it for as short a time as necessary.

“I feel protected, Being on constant observations is not an easy thing to deal with, especially when I do not have toilet and shower privacy but staff try to observe as discretely as possible” e.g. she showers with the curtain drawn. Male staff also seek assistance from a female colleague when the individual needs to use the toilet/shower.

- **Use of legislation**

Seventy five percent of the 81 of individuals who were under increased observation levels were detained under the Mental Health (Care and Treatment)(Scotland) Act 2003 at the time. However, the balance of positive and negative comments about the need for enhanced observation was the same from voluntary patients as it was from those who were compulsorily detained.

We noted that 1 in 4 people interviewed and subject to enhanced observation were in hospital on a voluntary basis. It is not always necessary to use compulsory measures where the person is under enhanced observation, e.g. because of suicide risk. If the person is being observed because of a risk of absconding, there is a greater risk of 'de facto' detention. In this situation, the person's rights may be better protected by compulsory measures, even where the individual appears to be

consenting. It can be difficult to decide whether the person should be detained and we are happy to be contacted for advice in the individual case. Regular review of observation level of those who are in hospital on a voluntary basis and of people's consent to any restrictions imposed as a result is important in protecting their rights in this situation.

- **Freedom to go out**

Fewer than a third of the individuals we visited were able to go out of the ward whilst under enhanced observation. Although this restriction may have been influenced by the ward environment, it was often perceived as being due to shortage of staff to provide an escort. However, we did find at least one way round this:

Good Practice Example

In one area, individuals can keep engaged with the life skills department to maintain a normal routine. Observations can then be carried out by nurses at the centre while people are engaged in social activities, arts/crafts, relaxation, solution focused groups, kitchen assessments and outings. (Mackinnon House)

Almost all were able to go outside once the observation was reduced to the general level.

Action needed

- Where observation is carried out in psychiatric wards, this should be in line with levels of observation defined in the CRAG guidelines.
- Individuals should be given an explanation of why they require enhanced observation and the level of observation reviewed regularly to prevent unnecessary restriction of freedom. This explanation should be documented and staff should remind the person why enhanced observation is necessary.
- Local managers and doctors should agree on a procedure for the delegation of authority to review observation levels so that any unnecessary restriction can be minimised
- Observation should be seen as a therapeutic intervention, an opportunity for engagement and not as a task to be undertaken. Ward managers should ensure that only suitably skilled staff are involved in observation and should seek feedback from individuals who have been involved in enhanced observation about their experience.
- Local services should develop training plans for all staff involved in observation. This training should include input from people who have experienced enhanced observation and should explore both the practicalities of the local observation procedure and the philosophy underpinning it.

Information provision

Many people reported that they were not given sufficient information about their care and treatment. Managers should ensure that there is a record of when information is given and whether the person has understood the content.

Healthcare professionals can make a significant positive difference to people's experiences of illnesses and of health services by offering good quality, relevant information in a caring way at an appropriate time. Provision of information is a principle of the 2003 Act.

What we expect to find

We would expect individuals to have been provided with information about the ward, their legal status, advocacy services, diagnosis, medication and any healthcare intervention.

They should also have easy access to written information material.

There should be a good understanding amongst staff about why good information provision is an important part of good quality healthcare. Staff should do all they can to help people understand the information they have been given. They should document what they did to achieve this.

What we found

Ninety per cent of those interviewed said they found staff to be approachable. Three quarters of people visited were happy with the information they were offered about the ward, their legal status, advocacy services, diagnosis, medication and any healthcare intervention.

One visitor commented:

The named nurse provided leaflets initially and then went over them again recently e.g. making complaints, information leaflets, leaflets on rights. Feels that it is a good idea for nurse to discuss them when person's mental health has improved as they are able to understand and retain information better at this stage.

And some positive comments from people visited

"The information is quite adequate not too much to overwhelm you. They give us leaflets and a wee book about the hospital."

"When you are admitted into the ward the staff show you around. They also give you written information about who your named nurse is, what groups are on, what you may want to attend."

The remaining minority responded that they had either not received this information or they did not remember if they had been provided with information. Unfortunately, this could not always be confirmed from the written record. Negative comments included:

"They blackmail you into it, take away your free time until you do what they tell you. I don't feel I am mentally ill. I'm not given information about mental illness".

"Haven't seen or been told of results."

Action needed

- Information provision must be incorporated into routine clinical practices and the staff should routinely record details in individual records of the information materials they have provided.
- There should be a documented means of checking that people have received, or been offered, the appropriate materials and of correcting the situation quickly if they have not.

- There should be periodic reviews to identify the points at which people are likely to need information and efforts made to communicate these once a person's mental health has improved.

REVIEW

A significant number of people we visited felt that they did not meet their named nurse often enough, and many did not know who their named nurse was. There was also a lack of feeling of involvement by individuals in their care and treatment. Ward managers should review the named nurse system and ensure individuals have the opportunity to participate in their care.

The multidisciplinary review provides a written record of the outcome of the meeting between health and social care professionals and the individual together with his/her representatives.

Regular reviews develop a consistent approach to care and help to build extensive knowledge of the person's needs and thereby maximise the value of the therapeutic relationship.

They provide an opportunity to monitor progress and help to develop care plans that reflect changing needs.

What we expect to find

Individuals should know who their named nurse is and be able to meet and review their care on a regular basis. They should also have regular contact with their psychiatrist and feel that they can have an input to discussions about their care with the support of carers or advocates if needed.

What we found

- **Contact with named nurse**

People are commonly allocated to a named nurse or key worker who they can approach during their time in hospital. The terms are often interchangeable and may also be used for a nurse allocated for the day.

In all the visits we visited the responses to the staff questionnaires suggest that the frequency of contact with the named nurse, falls within the range of "several times a day to at least once every 72 hours", depending on the stage of the person's progress towards discharge.

People told us

"They tell you each day who your named nurse is".

"They are approachable and easy to talk to".

"My named nurse, she takes an interest in me"

"I see my key worker once a week. It's before the MDT meeting on the Monday".

However, one in five of those who were interviewed did not know who their named nurse, or associate named nurse was. Only 60% felt that they saw their key worker often enough.

"I don't even know what she looks like".

"It is up to me to see her. She doesn't set times to see me".

"She was off for 3 months and I have seen her for about an hour in total since my admission".

- **Contact with psychiatrist**

From staff responses we found that reviews by responsible medical officers (RMOs) happen at a frequency of weekly or more in all the units we visited, and this was checked in randomly selected case notes. Also, around three quarters of the individuals who responded felt that they saw their consultant often enough.

Individuals reported they are routinely invited to the review meetings in almost all the units we visited. But only 66% of those interviewed felt they were involved in their care and treatment. This reflected a similar concern expressed by people in our unannounced visits to adult acute wards in 2007 (MWC, 2009).

Action needed

- A named and associate nurse should be allocated to each individual within the first 24 hours of admission. They should clearly identify themselves and their role as a named nurse to the person. This should also be clearly identified within the clinical records and care planning documents. The named nurse should ensure continuity of planned care in their absence by allocating an associate nurse within the first 24 hours.
- 1:1 reviews should be regular and the frequency must be based on assessment and identification of need. The named nurse should inform the person about the frequency and duration of these reviews.
- The named nurse should maintain a high level of communication with all those involved in the care and treatment of the person about their progress and recovery.
- The named nurse should positively address issues raised by the person and make these known to those involved in their care, especially if the person feels unable to do this for themselves. The named nurse should also address issues of concern to the person, especially where the person does not understand their care plan.
- Individuals should be reviewed by the Consultant Psychiatrist at least once weekly, and more often if required.
- All individuals and their carers or advocates, where appropriate, should be routinely invited to the review meetings. The individual should receive feedback about the outcome of reviews as soon as possible afterwards.

Discharge planning

Although we found evidence of discharge planning in almost all of the wards visited, many individuals were unaware of their plans for discharge. Doctors and ward managers should consider giving written as well as verbal confirmation of discharge plans to people in their care.

Effective discharge planning is essential to the safe and successful transition of individuals from hospital to the community.

It recognises that mental illness may impair many aspects of an individual's life, often for extended periods of time and also recognises the importance of engaging other agencies, service providers, carers and the individual. It supports an individual's safety, may reduce adverse events and aims for improved individual, family and carer outcomes.

By linking inpatient units with primary health care providers, carers, and community services, effective discharge planning performs a key function of all successful mental health services in maintaining continuity of care.

What we would expect to find

We would expect to find recorded evidence of discharge planning for all individuals. In addition, we would expect most people to be aware of and feel involved in the making plans for discharge.

What we found

- **Evidence of discharge planning**

We found evidence of active discharge planning in 90% of the sites we visited. We found that most of the units had comprehensive paperwork to record discharge planning, but only one third of them actually used them. Most of the sites used multi disciplinary team review sheets to record discharge plans.

Awareness of plans

Half of the people we interviewed responded to our questions on discharge planning. About 75% of them felt they were involved in their discharge planning. However, less than two thirds of respondents actually knew what their discharge plan was.

Action needed

- Services should review how discharge planning is recorded to make it more comprehensive and consistent. An identified key worker should be responsible for ensuring that each step of the discharge process is completed and understood by the person.

CONCLUSIONS

Most of the people we met reported generally good experiences on care and treatment in acute mental health wards. There are still improvements to be made to make sure that people are treated safely and with dignity and respect. If services take the action we recommend, we are confident that they will achieve this.

References

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Admissions to adult mental health inpatient services ~ Best Practice Statement, Glasgow, NHS QIS, March 2009

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Care and treatment of individuals on short term detention certificates (MWC, 2010)

Clinical Resource and Audit Group (CRAG). Engaging people: observation of people with acute mental health problems: a good practice statement. Edinburgh; Stationary Office: 2002.

Delivering for mental health. Edinburgh; Scottish Executive: 2006.

Our impressions of mental health acute admissions wards in Scotland with recommendations for improvements to in-patient facilities and services. MWC Unannounced visit report 2005

Rights, Relationships and Recovery, the Report of the Review of Mental Health Nursing in Scotland; Edinburgh, Scottish Executive, 2006

Specified Persons Guidance (MWC, 2010)

LIST OF HOSPITALS AND WARDS VISITED

TEAM	HEALTH BOARD	HOSPITAL	WARD	TYPE	BEDS
A	Ayrshire & Arran	Ailsa	Kyle	Adult acute	23
A	Ayrshire & Arran	Ailsa	Park	Adult acute	23
A	Ayrshire & Arran	Crosshouse	1D	Adult acute	23
A	Ayrshire & Arran	Crosshouse	1E	Adult acute	23
A	Dumfries & Galloway	Crichton Royal	Nithsdale	Adult acute	22
A	Dumfries & Galloway	Crichton Royal	Ettrick	Adult acute	24
A	Glasgow & Clyde	Dykebar	East - AAU	Adult acute	15
A	Glasgow & Clyde	Dykebar	Noth - AAU	Adult acute	15
A	Glasgow & Clyde	Dykebar	South - AAU	Adult acute	15
A	Glasgow & Clyde	Gartnaval	Henderson	Adult acute	20
A	Glasgow & Clyde	Gartnaval	Rutherford	Adult acute	20
A	Glasgow & Clyde	Gartnaval	McNair	Adult acute	20
A	Glasgow & Clyde	Ravenscraig	Dunrod G	Adult acute	25
A	Glasgow & Clyde	Leverndale	Ward 3	Adult acute	24
A	Glasgow & Clyde	Leverndale	Ward 4	Adult acute	24
A	Glasgow & Clyde	Parkhead	Ward 1	Adult acute	20
A	Glasgow & Clyde	Parkhead	Ward 3	Adult acute	20
A	Glasgow & Clyde	Parkhead	Ward 4	Adult acute	20
A	Glasgow & Clyde	RAH	Ward 2	Adult acute	30
A	Glasgow & Clyde	SGH	Ward 31	Adult acute	18
A	Glasgow & Clyde	SGH	Ward 32	Adult acute	18
A	Glasgow & Clyde	Stobhill	Armadale	Adult acute	20
A	Glasgow & Clyde	Stobhill	Broadford	Adult acute	20
A	Glasgow & Clyde	Stobhill	Struan	Adult acute	20
A	Glasgow & Clyde	Vale of Leven	Christie	Adult acute	20
B	Lothian	Royal Edinburgh	Meadows	Acute Admission	25
B	Lothian	Royal Edinburgh	Merchiston	Acute Admission	25
B	Lothian	Royal Edinburgh	Heritage	Acute Admission	25
B	Lothian	Royal Edinburgh	Balcarres	Acute Admission	25
B	Lothian	St Johns	ward 17	Acute Admission	30
B	Lanarkshire	Hairmyres	Ward 19	Adult acute	30
B	Lanarkshire	Hairmyres	Ward 20	Adult acute	25
B	Lanarkshire	Monklands General	Ward 24	Adult acute	25
B	Lanarkshire	Monklands General	Ward 25	Adult acute	25
B	Lanarkshire	Wishaw General	Ward 1	Adult acute	23
B	Lanarkshire	Wishaw General	Ward 2	Adult acute	23

B	Forth Valley	FDRI	Ward 1	Adult acute	24
B	Forth Valley	FDRI	Ward 18	Adult acute	29
B	Borders	Melrose	Huntlyburn	Adult acute	30
C	Fife	Queen Margaret	2	Adult Acute	30
C	Fife	Stratheden	Lomond	Adult Acute	26
C	Fife	Whyteman's Brae	Woodbank	Adult Acute	26
C	Fife		Rothies	Adult Acute	24
C	Grampian	Royal Cornhill	Drum	Adult Acute	28
C	Grampian		Crathes	Adult Acute	28
C	Grampian		Brodie	Adult Acute	29
C	Grampian		Corgarff	Adult Acute	28
C	Grampian	DR Gray's	4	Adult Acute	20
C	Highland	New Craigs	Ruthven	Adult Acute	24
C	Highland		Maree	Adult Acute	24
C	Highland		Morar	Adult Acute	24
C	Highland	Argyle and Bute	Succoth	Adult Acute	26
C	Tayside	Carseview	1	Adult Acute	24
C	Tayside		1	Adult Acute	24
C	Tayside	Murray Royal	Moredon A	Adult Acute	22
C	Tayside		Moredon B	Adult Acute	22
C	Tayside	Sunnyside	4	Adult Acute	22
C	Tayside		8	Adult Acute	6