Mental Welfare Commission for Scotland

Summary of outcomes from focussed visits 2010-11

Between April 2010 and March 2011, The Commission undertook 87 focussed visits to people receiving care for mental health problems or learning disability. We visited these people in various settings, including hospitals, care homes and prisons. We made 301 recommendations for improvement following these visits. When we followed these up, we found that services had taken satisfactory action in 76% of cases.

In this paper, we report on the main themes and outcomes from 74 of those visits. These were to people receiving treatment in the following types of care settings:

- Intensive psychiatric care and secure units
- Care facilities for people with learning disability
- Older people in hospital
- Older people in care homes
- People with mental disorders in prison
- Young people's care facilities
- Mental health continuing care and rehabilitation facilities
- Adult acute admission wards

There were 13 other visits that did not fall into these categories.

We have examined the main issues to emerge from these visits. We have given specific examples of improvements that services made after our visits. It was heartening to see that service managers paid great attention to our recommendations and acted on them.

Many of our recommendations addressed principles of Scottish mental health and incapacity legislation, the articles of human rights legislation and other important international conventions. We wanted to ensure that services were taking account of these when providing care and treatment. There are many examples in our reports of issues we raised. The commonest were:

- Care environments that did not appear to meet people's right to privacy and dignity (article 8 of the European Convention for Human Rights)
- Care plans that did not appear to comply with the principles of maximum benefit, participation and the range of options available

- Lack of attention to physical health, contrary to the right to the highest attainable standard of health (article 25 of the International Convention on the Rights of Persons with disability)

The following sections give more detail on the recommendations we made in each type of care setting.

Focussed visit summary: Visits to intensive psychiatric care and secure units

Number of visits 7

Number of recommendations 25

Recurring themes and areas for improvement

1. **Right to privacy and dignity**

The risk to individual privacy and dignity can be high in secure units. We wanted to be sure that interference with individual privacy and dignity was lawful and necessary. We made recommendations on:

- Poorly maintained or designed ward environments
- Free access to drinking water

Example of improvements following our visit:

Our recommendation where we found that people in a secure unit did not have ready access to drinking water. (Often, this is because one person has been drinking compulsively, but this does not justify denying everyone free access, especially as many medications cause a dry mouth).

All patients should have ease of access to water and other soft drinks unless contraindicated on an individual clinical basis.

The unit's response*:*

All patients now have full access to water and vending machines for other soft drinks

2. **Least restriction of freedom and lawful deprivation of liberty**

People treated in secure units suffer significant deprivation of liberty. This must be lawful and must, in line with the principles of mental health legislation, be the least restrictive of the person's freedom. We made recommendations about:

- Access to outside space
- The use of restraint
- The use of secure wards for informal patients

Example of improvements following our visit:

Our recommendation where we visited people in secure ward who had been restrained but did not understand why this had been done.

The ward manager should review the practice of how the use of restraint is communicated to patients. In addition to providing an explanation at the time, there should be a debrief with the person following use of restraint to discuss the reasons it was felt to be necessary.

The ward's response:

Staff will explain why restraint was use after the event. The use of restraint will continue to be recorded in the patient's care plan and reported through the appropriate system.

3. Provision of information

Principles of mental health legislation include participation of the patient and the provision of information. We expected to find that the people we visited were given appropriate information (and helped to understand it) about the security in the unit and the person's rights under mental health legislation. We made recommendations when this did not appear to have happened.

Example of improvements following our visit

Our recommendation where we found a lack of evidence that some people had been given information about their detention. Section 260 of the 2003 Act requires that hospital managers must give certain information and ensure they understand it. The ward had a checklist for doing this.

The section 260 checklist is not being completed consistently. There should be a review of the completion of case note documentation covering legislation-related matters and clarity provided for staff regarding expectations in relation to this.

The ward's response:

It is agreed that the "Section 260 Checklist" should be completed consistently. A copy of the "Section 260 Checklist" was sent to the Commission. (Ongoing inconsistency regarding this has been apparent on Commission visits across the mental health service in this visiting year. We are following this up to make sure that all people detained in this hospital are given necessary information).

Focussed visit summary: Visits to care facilities for people with learning disability

Number of visits 14

Number of recommendations 48

Recurring themes and areas for improvement

1. **Privacy and dignity issues in care environments**

People with learning disability have the same right to privacy and dignity as anyone else. Any interference with that right must be lawful and proportionate. Environments and practices in some place we visited did not seem to give people this right. We made recommendations about:

- Provision of secure personal space for people
- Maintenance of buildings and gardens
- Policies for observation, particularly video surveillance (see the section on visits in our annual report and the joint statement on our website on this topic)

Example of improvements following our visit:

Our recommendation where we found a hospital where there was a bedroom door that had been broken and not replaced, along with other examples of poor upkeep of buildings and gardens:

Maintenance of the building and garden should be completed timeously and be of a good standard. The missing bedroom door should be replaced immediately. A programme of improvements with appropriate completion dates should be provided for the Commission

The hospitals response*:*

The managers made sure that immediate work was carried out. They carried out other improvements over the next three months. (There is still some work needed and we will follow this up).

2. **Range of services available**

Legislation includes principles of benefit, reciprocity and a range of services to meet individuals' needs. We made recommendations where we found gaps in service provision. These included

- Generally poorly constructed care plans,
- Lack of access to psychological therapies
- Lack of provision of activity that meets the person's individual needs and preferences

Example of improvements following our visit:

Our recommendation where we visited several people in one unit who were not able to get out much. This was blamed on a shortage of occupational therapy staff.

Service manager will update the Commission on provision of activities and progress filling the OT post by the spring.

The unit's response:

An activities co-ordinator had recently taken up post within the ward. Since the visit a number of patients have safely increased their time off the ward and are now accessing time in the local community to facilitate their own shopping, exercise or a sociable meal. This has been achieved by the formulation of individually tailored progress plans based on information gained through the close assessments of patients. Nursing staff and the activity co-ordinator have been working together to create on-ward activities including art and craft sessions and a gardening group. The activity co-ordinator has also recently been able to increase his 1:1 work with patients which has created more opportunities within the main hospital hall and physiotherapy led gym. One of the nursing team has been tasked with securing information about local college courses on offer and plans are also near completion for a relaxation group within the ward.

3. Physical health

People with disabilities have the right to the highest possible standard of physical and mental health (UN Convention on the rights of persons with disabilities). We made recommendations where we found a lack of physical health checks and offers of screening tests. This was a common finding in hospitals and care homes.

Example of improvements following our visit

Our recommendation where we visited people who were not getting regular physical health checks in a care home:

The GP Practice covering this care home should be asked about undertaking routine annual health checks for residents.

The care home's response:

The care home manager confirmed that arrangements were made with GP to undertake physical health checks.

Focussed visit summary: Visits to older people in hospital

Number of visits 17

Number of recommendations 82

Recurring themes and areas for improvement

1. **Environments**

We made several recommendations aimed at improving care environments to meet people's right to privacy and dignity. These included:

- Making living areas more homely
- Providing more signs and environmental cues to help people with dementia
- Making best use of outside space

Example of improvements following our visit:

Our recommendation where we found that only part of a ward for people with dementia was well-designed

We would like to see the benefits of the obvious planning and work, that has gone into making the main body of the ward dementia friendly and homely, being applied to the bedroom and bedroom corridor area.

The hospital's response*:*

- *Bedroom area sectioned off with three colour schemes to support orientation and way-finding for patient,*
- *Land marks set up in corridor including purchases of lamps, cushions, pictures, clocks, vases etc*
- *Bottom windows painted with murals to aid way-finding and orientation*
- *Doors leading to patient rooms have prompts/way-finding support including numbers, pictures & life story images*
- *Bedroom doors colour coordinated to zones with top panels blocked with coloured squares*

2. **Care plans**

Principles of mental health and incapacity legislation include ensuring benefit, taking account of people's past and present wishes and providing appropriate services. We found several care wards where care plans were not individualised or did not appear to us to cover all the person's needs. In particular, we made recommendations where care plans:

- Did not contain information about people's life story, like, dislikes and interests
- Did not contain information about the need for activity or its benefit for the person
- Did not address appropriate use of people's own money to provide extra activity to improve their quality of life.

Example of improvements following our visit:

Our recommendation where we thought activity available on one ward was insufficient:

Activity programmes should be individualised and based on the patients' interests and wishes. Evidence of the effectiveness of activities should be recorded in individual case records as recommended in the Mental Welfare Commission report "Where do I go from here?"

The hospital's response:

A programme of OT activities does take place on the ward. The nursing staff also engage with the patients and an activity schedule has been introduced. An individualised activity recording system is to be introduced. The range of activities in this programme will be increased to include more patients.

3. Compliance with incapacity legislation

Many of the people we visited lacked capacity to make decisions about their welfare, treatment or finances. We wanted to ensure they were being treated in accordance with the Adults with Incapacity (Scotland) Act 2000. We made recommendations if they were not. Areas of recommendation addressed:

- Poor compliance with part 5 of the 2000 Act (medical treatment)
- Inadequate recording of the powers of attorneys and guardians
- Poor staff knowledge of relevant legislation

Example of improvements following our visit

Our recommendation where we found that medical treatment was not being properly authorised by a "section 47" certificate of incapacity as required by the 2000 Act:

The files of all residents are to be reviewed to ensure that Section 47 certificates with treatment plans attached to them are in place where relevant.

The hospital's response:

All S47 certificates, treatment orders, certificates of guardianship and interlocutors are now to be stored consistently in the individual's file with the personal plans relating to mental state and cognition. Treatment plans given to GP for completion

Focussed visit summary: Visits to older people in care homes

Number of visits 9

Number of recommendations 38

Recurring themes and areas for improvement

1. **Compliance with incapacity legislation**

Many of the people we visited lacked capacity to make decisions about their welfare, treatment or finances. We wanted to ensure they were being treated in accordance with the Adults with Incapacity (Scotland) Act 2000. We made recommendations if they were not. Areas of recommendation addressed:

- Poor compliance with part 5 of the 2000 Act (medical treatment)
- Inadequate recording of the powers of attorneys and guardians
- Poor staff knowledge of relevant legislation

Example of improvements following our visit:

Our recommendation where we found that care homes did not have good records of attorneys and guardians. Staff seemed unaware of the importance of this and had limited knowledge of the legislation.

The contact sheet for each resident should clearly document the status of Power of Attorney and Welfare Guardian. The powers held under Part 2 and 6 of the Act should be carefully recorded and discussion regarding the management and possible delegation of the powers discussed with the manager of each unit. Private Guardian and local authority supervisors contact details should be recorded and updated. Consideration should be given to using the MWC checklist.

The care home's response*:*

Tracker put in place for all clients who have a Power of Attorney/Guardianship. Record identifies Power of Attorney/Guardian. Copy of MWC checklist and good practice guidance being used. Training sessions and workshops for staff to be developed.

2. **Management of "challenging behaviour"**

Under incapacity legislation, any intervention must be of benefit and must restrict the person's freedom as little as possible. We visited people with dementia whose behaviour appeared to be a problem. Sometimes, we thought that staff could have managed this better. Our recommendations addressed:

- The importance of reviewing sedative medication on a regular basis
- Care plans that did not appear to have an appropriate range of interventions

- Staff knowledge and training

Example of improvements following our visit:

Our recommendation where we found care plans that did not provide individualised approaches to challenging behaviour and where staff appeared to be struggling to manage some residents. In this case, the care home manager put a lot of effort into making improvements and did more than we actually recommended.

The Mental health and Challenging Behaviour component of the residents care plan should be reviewed and more personal details should be added where required.

The care home's response:

Care Plans to be reviewed in relation to mental health and challenging behaviour for individuals. Staff to attend Challenging Behaviour training to enhance staff members' understanding of mental health component/best practice in relation to medication. Trackers to be compiled in relation to psychoactive medication to identify areas for improvement/staff who require support

3. Activity

Keeping active is an important part of everyone's life. We wanted to see interventions that were of benefit to residents and took account of their wishes and preferences. This was an important message in our joint report with the Care Commission, *Remember, I'm Still Me."* We made recommendations about:

- The use of life stories to guide provision of activity
- The range of activities available and a record of benefit
- The creative use of people's individual money to provide extra outings and activity that would improve quality of life.

Example of improvements following our visit

Our recommendation where we found care plans that included a section on "keeping active" that did not appear to provide a good record of activity.

The "keeping active" part of the care plan should be reviewed by each unit manager and activity coordinator and updated with more information included where required. Activities should also be part of the six monthly care plan and it should be recorded which activities the person enjoys participating in and those which the person has been encouraged to take part in but declined.

The care home's response:

All personal plans in regards to "keeping active" are reviewed by named nurse /key worker. At all 6 monthly reviews, activities are discussed with patient /family advocate. Updated monthly or on patient request.

Focussed visit summary: Visits to people with mental disorders in prison

Number of visits 4

Number of recommendations 8

(We undertook themed visits to prisons this year. The findings and recommendations from these will be published separately)

Recurring themes and areas for improvement

1. **Access to advocacy**

Any person with a mental disorder has the right of access to independent advocacy. NHS Boards and local authorities must secure the provision of advocacy services *(Mental Health (Care and Treatment) (Scotland) Act 2003)*. We found that prisoners with mental disorders did not have ready access to advocacy. We made recommendations about this in three of the four prisons we visited. This also features in the national recommendations we are making in our themed report. We have not seen much progress so far despite our recommendations.

Example of improvements following our visit:

Our recommendation where we found that prisoners did not have sufficient access to advocacy

Prisoners with mental disorder should have access to independent advocacy. We were told during the visit that advocacy services are available to prisoners, but only in crisis as a one off intervention.

The prison's response*:*

Contact has been made with a local agency who will provide urgent advocacy. National Advocacy Providers have been invited to forensic network meeting to discuss how this can be moved forward.

2. **Access to a range of mental health services**

Psychological approaches to mental health problems may be helpful for some prisoners. We found that these were not always available. We made recommendations about increasing the availability of psychology and others with specialist therapeutic skills

Example of improvements following our visit:

Our recommendation where we found a lack of availability of talking therapies:

Prisoners should have access to talking therapies within the prison. Clinical psychology input focuses almost exclusively on undertaking risk assessments. No

cognitive behaviour therapy has been available for some time to prisoners, because of the lack of trained nursing staff.

The prison's response:

Prisoners with mental health problems are advised by the mental health team that they can access their service. Prisoners have access to less formal talking therapies - 1:1 nursing intervention, breathing space, living life to the full, etc. There is a clear intention to increase the amount of staff trained in psychological interventions, in the draft mental health plan. We have now doubled the number of mental health nurses.

Focussed visit summary: Visits to young people's care facilities

Number of visits 9

Number of recommendations 27

Recurring themes and areas for improvement

1. **Attention to mental health needs of young people in residential care**

People with any form of disability have the right to the highest possible standard of mental and physical health (International Convention on the Rights of Persons with Disabilities). Young people in residential care setting have high rates of mental health problems. Good links with primary healthcare and specialist child and adolescent mental health services (CAMHS) are essential. We made recommendations when we found:

- Problems with access to out-of hours healthcare
- Difficulty in getting access to specialist CAMHS teams.
- Lack of training in mental health for care staff

Example of improvements following our visit:

Our recommendation where we found that staff in residential accommodation has insufficient training to meet the mental health needs of some of the people we visited:

We recommend that discussions should be undertaken with the NHS Board to seek mental health training for staff.

The unit's response*:*

Several developments including training for trainers by Young Minds will take place by the end of November 2010. Once this has taken place a rolling programme will be implemented that will train staff on models of risk and reliance.

2. **Range of services available in NHS units**

Child welfare is an important principle of mental health legislation. We wanted to see that young people had access to a full range of health and education services. This was not always the case. There were problems when young people are admitted to regional units. We made recommendations on:

- Access to education where the young person is from a different local authority area
- Access to some specialist physical health services where the young person is from a different NHS area

Example of improvements following our visit:

Our recommendation where we found young people in a regional specialist NHS unit who were having difficulty getting funding for their education while in the unit.

Managers and the Board should engage education authorities in resolving the issue of equal provision of education to all young people in the unit.

The unit's response:

The educational needs of a young person will be assessed to determine suitability for receiving education whilst an inpatient. The referrer will be involved in these discussions and the education provider notified of the outcome. Any pupil on a school role can access the school service, subject to local authority agreement. The school is run by the local authority Hospital and Outreach Teaching service and therefore pupils from Council area are taught without charge. When a pupil from outside the council area attends the school, the pupil's local authority and head teacher are informed. The local authority is then charged an hourly rate.

3. Transition and aftercare

Transition from young people's services to adult services can be difficult. Also, transfer of care from specialist in-patient services to community teams can be difficult, especially where the person's home is distant from the hospital. Our recommendations addressed:

- Use of the Adults with Incapacity (Scotland) Act 2000 when the young person reaches 16,
- Planning for aftercare when the young person leaves residential accommodation,
- Planning for aftercare when the young person is discharged from specialist NHS care

<u>Example of improvements following our visit</u>

Our recommendation where we that discharging some young people was difficult because of poor links with some community teams.

The ongoing review both within the unit and with regional partners should be prioritised to ensure that all parties share a clear understanding of the goals of admission and of the responsibilities on all sides to ensure that discharge planning is a part of the process from the earliest stage.

The unit's response:

A development day has been undertaken to ensure that all parties were clear regarding the process of admission and the responsibilities of all sides to ensure the discharge planning is part of the process from the earliest stage. This process will be facilitated by continuing to have an active case manager from the locality team throughout the inpatient stay.

Focussed Visit summary: Visits to people in mental health continuing care and rehabilitation facilities

Number of visits 6

Number of recommendations 24

Recurring themes and areas for improvement

1. Environment

Several of the facilities we visited were in the process of planned closure and relocation. We were concerned in some instances about that the lack of ongoing maintenance and refurbishment in the period before closure. We made a number of recommendations aimed at improving these care environments to meet people's right to privacy and dignity. These included:

- Replacement of worn furniture
- Timing of unit refurbishment to minimise disruption to patients
- Personalisation of bedrooms

Example of improvements following our visit

Our recommendation where we had concerns that patient care might be adversely affected by renovations:

Timing of the unit refurbishment should be carefully considered to minimise disruption to patients' care and treatment

The hospital's response:

The residing patients moved to new facilities allowing this area to have the relevant planned refurbishment take place prior to the transfer of a new patient group. A small working group was developed and an action plan implemented to upgrade the garden area with new furnishings, patio and flower beds. Patients report that they are pleased with their new facilities and the refurbishment did not affect their care and treatment

2. Care Plans

Patients in continuing care/rehab settings should have the opportunity to maintain or regain living skills. We wanted to ensure that care plans were supporting this move towards recovery. Principles underpinning mental health legislation include ensuring benefit, taking account of peoples' past and present wishes and considering the full range of options for care. We visited wards where care plans were standardised, often limited in scope and showed little evidence of patient involvement. In these instances, we made recommendations which addressed:

- Lack of individualised assessment of needs

- Limited involvement of patients in developing care plans
- Narrow range of therapeutic options

Example of improvements following our visit:

Our recommendation where we had concerns about the quality of care plans :

Care plans should be based on a holistic assessment of individual needs and address all aspects of the individual's care and treatment. Care plans should contain an individual activity programme and a record of the outcome of interventions including social and recreational activities. Care plans should evidence patient involvement in their development.

The hospital's response:

The Practice Development Team have completed training with the staff on Scottish Recovery Indicators and utilising the principles of the 10 Essential Shared Capabilities with the implementation of the generic ACP due in May 2011. Introduction of Releasing Time to Care with planned implementation programme to commence May 2011. All care plans have been reviewed and updated with patients/carers/family/advocacy involvement.

3. Activities

We looked for evidence of an 'activity culture' which would reflect individuals' personal choices, preferences and abilities and promote physical health and mental wellbeing**.** We made recommendations about:

- The need for individualised activity programmes
- Lack of OT provision
- Recording the outcomes of social and recreational activities to demonstrate the benefit to the individual

Example of improvements following our visit:

Our recommendation where we were concerned about the apparent lack of meaningful activities for patients on a 'slow stream' rehab ward suffering from 'pre-closure blight':

Managers and staff should establish a programme of meaningful activities to meet the individual needs and preferences of all the residents of the ward and there should be user involvement in this process.

The hospital's response:

Recreational department will remain on the site until closure. A timetable of recreational activities displayed on all notice boards in the ward. Recreational activity is discussed at weekly patient meetings. Recreational staff are rostered daily to

support the provision of both social and recreational activity within and outwith the ward.

Focussed visit summary: Visits to people in adult acute admission wards

Number of visits: 8

Number of recommendations: 24

Recurring themes and area for improvement

1 Access to staff

People who are acutely mentally unwell must be able to discuss their problems with nursing staff. This should include dedicate1:1 time with key members of staff.

Example of improvements following our visit

Our recommendation where patients told us they did not have enough access to staff and often did not know who to approach

*Staff should be proactive in providing 1:1 time for patients and this should be recorded. Patients should be clear which member of staff is allocated to them on each shift***.**

The hospital response:

Staff are allocated a client 'group' at the beginning of each shift. The staff described speaking to all of their group on an individual basis. The content of the interactions is recorded in care plans. All staff will inform their allocated patients that they are indeed allocated to them. Staff describe specific 1:1 interactions but often record this as a 'nursing note'. This has been discussed to ensure correct recording. The staff were also reminded that their client group felt they were not proactive enough in providing 1:1 interactions with their patients and ensure this time is protected.

2 Privacy and dignity

Adults admitted to admission wards in the acute phase of their illness are often temporarily unable to protect their own privacy and dignity and therefore it is incumbent upon staff to take extra care to ensure this fundamental human right is protected. We made a number of recommendations in relation to

- Improving privacy for individuals in dormitories
- Screening of bedroom windows

Example of improvements following our visit

Our recommendation where we were concerned that unscreened clear glass bedroom windows were causing patients' dignity to be compromised :

Recommend that hospital managers arrange, as a matter of urgency, for those windows into bedrooms which have clear glass to be screened effectively, to ensure that there is no breach of privacy for individuals using these bedrooms.

The hospital response;

In this situation, we did not receive a response despite several reminders. We are undertaking an unannounced visit and will escalate this matter to the Chief Executive of the NHS Board if we have not seen satisfactory progress.

3 Therapeutic activities and talking treatments

There should be an active presumption based on the principles of benefit and reciprocity that people admitted to an acute admission ward are offered appropriate care and treatment. A range of recovery focussed medical, nursing and psychological interventions should be available.

We made recommendations about:

- Need for a range of structured activities and therapies to aid recovery
- Lack of psychology provision

<u>Example of improvements following our visit</u>

Our recommendation where we were concerned to find a lack of activities and therapies

We recommend provision of a range of activities, to develop and maintain skills, to build on other recovery focussed initiatives and therapies, and to relieve boredom, should be part of standard in-patient mental health care.

The hospital response ;

A system is now in place documenting activities undertaken by patients. The system is contained within the care plan and reviewed regularly.

With respect to time spent within bedrooms, a clear system of recording is now in place, including time spent in room and reason for time in room. In addition, a system has been put in place for the rooms with alarms where patients can call staff more discreetly.