mentalwelfare commission for scotland

Recommendations from our focussed visits and action taken

Principle focus: Individualisation and participation

We pay particular attention to the principles of mental health and incapacity legislation. We also support the development and use of the Scottish Recovery Indicator (SRI). When we look at individual care plans, we want to see whether they deal with all the person's needs and take account of the person as a unique individual. We look at how the person is involved in the development of the care plan and how much his/her own views are taken into account.

This year, we made 19 recommendations about individual focus and participation. Common findings were:

The "standard" care plan.
Seven of our recommendations addressed this issue. We found services that had, for each identified need, a standard care plan that showed no evidence of being tailored to the individual. We asked services to make their care plans more responsive to individual needs and choices.
Example – we found a care home where care plans varied little between residents and did not reflect personal preferences and choices. After our visit, the care home invested in training for staff on personalised care plans and held meetings with relatives to get better information about individual interests.

Life stories.
In our joint report with the Care Commission, "Remember, I'm still me", we commented on the importance of knowing the person with dementia as an individual. Life stories are an important way to achieve this and can be very helpful in providing individual care. We made five specific recommendations to hospitals and care homes where we found life stories to be absent or patchy.
Example – in one hospital, we visited people in four wards for people with dementia. In three, life stories were available for most, but not all people. In the other ward, there were very few life stories. After our visit, the service manager gave this a lot of attention. She made sure that all wards obtained life story information wherever possible. She recognised that this work should start much earlier for people with dementia. Staff in community teams now help people with dementia and their carers to complete life stories that can then accompany the person if he/she needs to enter a care home or hospital.

Holistic plans.
We made four recommendations about care plans that did not appear to identify all individual needs. We found care plans that addressed basic needs (e.g. nutrition, hygiene, safety) but not the need for socialisation, enjoyment or improving independence.
Example – in a hospital for people with learning disability, we found that care plans did not mention how to manage behaviour difficulties and there was little mention of improving independent living skills. After our visit, staff met with patients and relatives to set individual targets for improving living skills. They are still working on improving their care plans for behaviour management and we will be visiting again to see what progress they have made.

Principle focus: the duty to provide appropriate services ("reciprocity")

The 2003 Act requires the provision of appropriate services to people that are subject to compulsory treatment. We think that appropriate services should be provided for everyone we see and do not want to see a "two-tier" service. We make recommendations where we find that the people we see are not getting the services that meet their needs. We made 31 recommendations in this category. Commonest issues were:

Activities. We place great importance on therapeutic and recreational activity. For many years, we have been making recommendations to improve activity provision. This has been successful and we find that most people get good access to activities. We made 11 recommendations for improvement in our focussed visits this year.

Example – we found one hospital where there was generally good activity but this was not available for people detained in the intensive psychiatric care unit (IPCU). Following our visit, an occupational therapy technical instructor was allocated to the IPCU and activity provision increased greatly.

Psychological therapies.

In "Delivering for Mental Health", there is a commitment to increasing the availability of psychological therapies. It is important that these therapies are available to people with severe and enduring mental illness in hospital. As well as specific therapies, we wanted to see whether patients got "one-to-one" time with their key workers to discuss progress and problems. We made nine recommendations about this. Progress has been generally slow because of a lack of suitably trained people.

Example – in a secure unit, we found that patients should have been getting one-to one sessions with their key worker. This varied greatly; some patients did not know who their key worker was. The unit introduced a contact sheet to ensure that staff gave patients one-to-one time and invested in training in psychological therapies for staff, including introducing new specialist nursing posts.

Rehabilitation and provision of community services.

People should not need to stay in hospital where there are viable alternatives. This needs all health, social work and other services to work together. Usually, we find good partnership working but this is not always the case.

Example – the most worrying example was a rehabilitation unit where several people were ready to move on but there was no alternative provision. We met two people who had been "stuck" for some time and were very frustrated. As we had not had seen action on our previous concerns, we took this to a meeting with the NHS Board and local authority. There was a lack of supported accommodation in the area. We told them that we would take the matter further if the people we saw were not offered alternative accommodation within three months. While we were pleased for those people that action was taken, we remain concerned about the lack of services in this area and will be monitoring the situation carefully.

Other recommendations included access to speech and language therapy, dieticians and general availability of medical and nursing time.

Least restriction of freedom versus right to safety

One of the most difficult dilemmas in the care of people with mental health problems and learning disability is getting the balance right between keeping people safe and allowing them freedom. We have given guidance on these issues for many years, e.g. our broad guidance on the restraint issue, "Rights, Risks and Limits to Freedom". Fourteen of our recommendations addressed these issues. We want to see evidence that, when restricting individual freedom, the risks and benefits have been properly considered.

Example – locked doors are the most obvious ways to restrict people's freedom. We found two locked wards where very few people were detained. Many people in the ward had the ability to go out safely but had to ask staff to unlock the door before doing so. We recommended that the units review their policies to make sure that doors were only locked when necessary and patients were told why the door was locked. "Slow doors", with delayed opening can give staff time to check who is entering and leaving and are less restrictive.

Right to privacy and dignity: staff behaviour

Article eight of the European Convention for Human Rights (ECHR) gives people the right to privacy, dignity and respect for family life. Any interference with that right must be necessary and proportionate. We find that staff often do all they can to give people privacy and dignity. We only made five recommendations about this, three of which were about providing assistance at meal times for people with dementia. In our report on older people in acute mental health care, "Where do I go from here", we emphasised the importance of a good eating experience and the need for protected mealtimes for staff so that they can concentrate on helping people that have difficulty attending to their own nutrition.

Example – in an NHS unit for people with dementia, we found that dining areas were sparse with no place mats or condiments (some patients had misused them through lack of judgement). There were not enough tables in one area and we saw people eating with food balanced on trays on their knees. Some people were too restless to be able to sit down and eat. Despite a policy of "protected mealtimes", staff were being interrupted by phone calls and visitors. The unit manager arranged for extra tables and finger food for people who could not sit for long and who preferred to eat on the move. Greater staff presence during mealtimes meant that people could eat more safely and use appropriate condiments and equipment safely.

Example - We found one hospital ward where staff had locked the toilet doors and patients had to ask for access to the toilets. This was because there had been an incident where a patient had locked himself in the toilet and caused damage. We told the staff that we thought this was an over-reaction and the denial of access to toilets without asking staff was a breach of privacy and dignity. Individual risk management should ensure that an individual is safe without interfering with the dignity of others. They agreed to review their practice and we will visit again to check that this now happens.

Right to privacy and dignity: physical environments

A recurring feature of all our reports is the physical environment of hospital wards. Where they do not afford people the right to privacy and dignity, the NHS may be

acting in breach of article eight of the ECHR. Where they do not make reasonable adjustments for the disabilities of people in the ward, this could breach disability discrimination legislation. It is depressing that we had to make 26 separate recommendations about physical environments that did not afford people the rights to which they were entitled. Common issues were:

Absence of signage and cues for people with dementia.
There is ample evidence that good environmental design and cues can be of great value for the care of people with dementia. Even in old buildings that were not designed for people with dementia, there is much that can be done. Even in new, well-designed units, we sometimes found an absence of environmental cues. This reduced the benefit of good design. We made ten recommendations about this.
Example – in one NHS unit for people with dementia, we found good use of colour and décor to aid orientation. Signs for toilets and the dining area were either absent or far too small for people with dementia, especially if vision was impaired. There were no cues to help people recognise their own rooms. We made recommendations and visited again after two months. Most rooms had personal boards to aid recognition and new signs had been provided. More could be done still and staff are still working on better ways to guide people around, with advice and support from the Stirling Dementia Services Development Centre.

Access to outside space.
We attach great importance to outside space and garden areas. This is an aspect of care that continues to improve. Most places we visit have appropriate access to outside space. We made three recommendations about garden areas for people with dementia. In all cases, there were garden areas provided but people were not getting access. Health and safety was given as a reason, but usually there was a lack of staff time to supervise people and we encouraged staff to see the importance of getting outside.
Example – we found a unit for people with dementia that had an excellent, dementia-friendly garden that was seldom used. Our visitors had difficulty finding their way into the garden. The unit manager initiated a project to develop the garden area. This is being led by a new occupational therapist.

Smoking. There is a move towards smoke-free mental health services. We still see facilities with smoking rooms that are not adequately ventilated. Whatever the pros and cons of making all environments completely non-smoking, there is no excuse for non-smokers being exposed to passive smoking. While this happens less often than it used to, we still made three recommendations this year about inadequate ventilation of smoking rooms.

Generally poor space, décor, furnishings and odour.
The remaining recommendations dealt with a variety of shortcomings of physical environments, usually of hospital wards. These included:

- Smell of urine from carpets (three cases). We demanded, and got, urgent action. Nobody should have to live in such conditions and we should not have to tell services this.
- Lack of personal space (two cases). This was a particular issue in intensive psychiatric care units (IPCUs). We undertook work with NHS Quality Improvement Scotland and others to examine the care of people in IPCUs.

We found one unit that, when full, had insufficient personal space for all patients. Managers are reviewing the unit and are trying to cut the number of beds.

- Poor toileting and shower facilities. This was a particular issue in one mixed sex IPCU where women had to access the toilets and showers by walking past male dormitories. We asked for action to address this.
- Lack of general maintenance. Where we commented on poor furnishing and décor, it appeared that there were no regular environmental checks and no rolling programme of maintenance. If self-inspection and regulation are going to be successful, hospital managers must attend to the lack of dignity afforded by some environments. Among the worst examples was the IPCU in one hospital where we found stained mattresses, one with old bloodstains, lack of wardrobes for patients and unfinished painting repairs. Staff had ordered replacements but none had been forthcoming. We were concerned that we did not get an initial response to our concerns and took the matter to a senior manager to make sure the necessary improvements were made.

People often stay in mental health care for long periods of time. National care standards for care homes do not apply to the NHS. We want to see more consistent application of acceptable standards of accommodation across the spectrum of care.

Compliance with the Mental Health Act

Under the Mental Health (Care and Treatment) (Scotland) Act 2003, we promote best practice and can investigate any improper actions. We made 14 recommendations where we found hospitals that were treating people unlawfully or risked doing so. The commonest issues were:

Compliance with medical treatment provisions.
Treatment must be given in line with part 16 of the Act. Usually, we found good awareness of the provisions of part 16. We made two recommendations where we found that forms authorising treatment were not available along with prescribing and recording sheets. A particular risky situation was where a patient was transferred to a general hospital but the treatment certificate did not accompany him and general hospital staff had no awareness of the Act. Emergency treatment is a particular risk and is not always recorded and reported to us. We are conducting unannounced visits this year to check that people are being treated lawfully.

"Specified persons" procedures.
Interference with privacy by searching people, or taking samples to test for drugs and alcohol, restricting visitors, or restricting communication by mail or telephone, carry safeguards under the Act. Any patient subject to these restrictions must be a "specified person", a decision that must be justified, documented and reviewed. This ensures that any such interference is necessary and proportionate. We made four recommendations where we found that staff had poor understanding of these procedures. We have produced guidance on implementing these procedures.
Example – in one secure unit, we found that staff did not understand the regulations on specified persons. They did not know which of their patients were specified persons and our visitors could not find records of the reasons why patients were made specified persons. We raised this with managers who introduced a "specified

person" recording sheet, information for patients and visitors and developed a training course for staff.

Care plans ("section 76").
We made three recommendations where we found care plans absent or inadequate and we drew attention to our guidance on this matter.

Information for patients.
Providing information to patients to assist in participation is an important principle of the Act. We made three recommendations where we found that information was not being provided or was inaccurate.
Example – one hospital had an information sheet that told patients that they could be treated without consent for two months from the start of a compulsory treatment order before an independent opinion is needed. We pointed out that this was wrong – the two months starts from the first time medication is administered, including during emergency or short-term detention. We made sure that the hospital corrected this.

Training issues
Most of our recommendations identified that some staff have not been trained in some important aspects of the Act. Even among medical staff, knowledge can be patchy. Managers were generally encouraged to improve training for staff. We are raising issues of refresher training for medical staff with the Scottish Government.

Compliance with the Adults with Incapacity Act

We made 18 recommendations about compliance with the Adults with Incapacity (Scotland) Act 2000. Some of our recommendations covered more than one issue. Almost all of these were from our visits to people in care homes. The most common issues were:

Knowledge of the powers of welfare guardians and attorneys.
In eight cases, we found that the care home did not have updated records of the powers or even who the attorney or guardian was. In a further two cases, the procedures for consulting the attorney or guardian were inadequate. This meant that persons with the legal power to make decisions about the resident's welfare and medical treatment may have been at risk of being excluded from important decisions.
Example – in one care home, we found that there was a list of local authority welfare guardians but not private guardians and attorneys. The staff paid great attention to the principles of the 2000 Act and had general good involvement of relatives. As a result of our visit, they recognised the need to involve attorneys and guardians more fully in decision-making. By the time we left, they had downloaded our guidance on working with the Act and were starting to complete documentation of all attorneys and guardians and their powers.

Compliance with part five of the Act (medical treatment).
We raised this in twelve of our recommendations. We found several care homes where people who could not consent to medical treatment did not have "section 47" certificates of incapacity. In some cases where we did find certificates, they were very broad and not tailored to the medical treatments being given. We did find very

good examples of certificates with treatment plans, but sometimes these were kept within the GP's records and not available to care home staff who were administering treatment. In one case, we found that GPs were attempting to charge for providing these certificates. They cannot claim a fee for this and we raised this matter with the NHS Board. We thought that GPs may have confused this certificate with the one for incapacity to manage finances, for which a fee is chargeable.
Example – we found a care home where some, but not all residents incapable of consenting to treatment had section 47 certificates but no treatment plans. As a result of our recommendations, all residents with certificates of incapacity now have treatment plans in place and the GP is assessing the capacity of all residents at regular reviews and providing certificates of incapacity and treatment plans where needed.

End-of-life decisions.
We found a group of care homes in one area where policy on resuscitation in the event of cardiac arrest was inadequate. Staff were not appropriately trained and decisions were not made on an individual basis. Following our visit, all decisions were made and recorded in individual care plans and there was a process of basic resuscitation training for all staff.

Money management.

It is very important that people's money is used for their benefit. Where the person lacks capacity, there are a number of ways to manage their money. Our guide "Money Matters" outlines the options available. We made five recommendations this year where we thought that money was not being used well enough for the benefit of individuals.
Examples – we found four NHS units with several patients who lacked capacity to manage their finances where procedures were inadequate. There was little evidence that the use of patients' money was being reviewed. In all cases, managers instigated a programme of reviews of money management for all patients every six months. This should be standard.

Prison issues

Generally, we found that prison health services paid good attention to the mental health of prisoners. We made recommendations in most prisons about advocacy and mental health first aid.

Advocacy.
We made five recommendations about the provision of independent advocacy. We found that advocacy was sometimes available for prisoners with mental health problems or learning disability. For some people, advocacy was not available. Even where it was available, it was not actively promoted within the prison. It is the responsibility of NHS Boards and local authorities to make advocacy available. This duty extends to people with mental disorders in prison. We recommended that prison staff contacted local advocacy organisations and, if they had problems, contact the local NHS Board. We are also raising this matter gore generally with the Scottish Prison Service. We are pleased that some progress has been made. For example, one of the prisons we visited now has input from advocacy twice a week.

Mental health first aid. Training in this can be of great value to people who are not specialists but who are in professional contact with individuals who have mental health difficulties. It outlines some of the common mental illnesses and gives advice on how to help people in situations of mental health crisis. Some prison staff have been trained in mental health first aid. We found that many staff had not and we made recommendations to the prison managers and the Scottish Prison Service. We think that more need to be done to make sure that as many staff as possible have this training.

Conclusions

We have identified some important actions from the recommendations made following our focussed visits. While services can learn some valuable lessons from all of our findings, we think that there are some areas of care and treatment that could particularly benefit from improvement across the whole of mental health care in Scotland.

- Services could improve provision of holistic care plans which evidence personalisation and choice. The Scottish Recovery Indicator is a useful tool to measure whether services are providing enough focus on individual rights and choice and are meeting people's needs.
- There are still gaps in the provision of some services, notably psychological therapies. NHS Boards and the Scottish Government Health Directorate should work to close these gaps.
- Human rights are very important in mental health care. The Scottish Commission for Human Rights should look at our findings and discuss with us how best to improve the attention given to the Human Rights Act in mental health care.
- Staff need ongoing refreshment in the use of mental health legislation. Knowledge of some provisions, notably those relating to "specified persons" is patchy. We also have concerns about compliance with medical treatment safeguards and are studying this further this year.
- There is still poor compliance with the medical treatment provisions of the Adults with Incapacity Act and poor understanding of the Act in general. We have identified this consistently over the past few years. More needs to be done to get doctors to comply with the Act and make sure that care staff know more about its use.

Dr Donald Lyons
Chief Executive
Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh EH12 5HE
0131 313 8777