



**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:** Lammerlaw Ward,  
Herdmanflat Hospital, Haddington, EH41 3BU

**Date of visit:** 14 January 2019

## **Where we visited**

Lammerlaw Ward is a 16-bedded mixed inpatient complex care ward for older people with a diagnosis of dementia. The ward is the only inpatient service remaining on the Herdmanflat Hospital site.

We last visited the ward on 8 May 2018 and made a number of recommendations related to auditing case files, improving care planning, and access to activities on the ward.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendations, and review issues raised with us by carers since our last visit.

## **Who we met with**

We met with/or reviewed the care and treatment of eight patients, and received feedback from one carer.

We spoke with the service manager, nurse in charge, members of the nursing team, and the activity co-ordinator.

## **Commission visitors**

Alison Thomson, Executive Director (Nursing)

Juliet Brock, Medical Officer

Tracey Ferguson, Social Work Officer

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

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

The relative we spoke with was positive about the care their family member was receiving. Where complaints had been raised previously regarding individuals, the service manager was following these up and we continue to monitor individual cases.

We were told that staffing levels remain a challenge for the team and there had been recent changes in senior nursing roles due to staff sickness, however overall there was more stability in the nursing team than when we last visited.

The service manager confirmed that the move to the new purpose-built unit at Roodlands Hospital is due to take place in September 2019. Managers were about to start preparing the team, patients, and relatives for this move. We recognise that this will be a significant period of transition for the staff team.

When we last visited the service, an improvement plan was underway following an independent audit of clinical practice on the ward. On this visit we were told about

quality improvement work that the service manager was continuing to lead. This included a number of training events that had recently taken place.

The ward team comprises a lead psychiatrist, nursing staff, an activity co-ordinator, and health care assistants. The occupational therapy (OT) post remains unfilled. A local GP visits three times a week to review patients' physical health, and provides additional telephone consultation when required.

A ward round takes place weekly, in addition to monthly team meetings.

Input from other professionals including dietetics, speech and language therapy, and physiotherapy, can be arranged on a referral basis. When psychological interventions are required, the team can refer to the East and Midlothian Psychological Assessment Team (EMPAT).

The team have received support from psychology in arranging recent dementia training days for staff. Individual members of staff told us they had not yet received dementia training.

When reviewing documentation we found the inpatient files we viewed were generally poorly organised, making it difficult to follow the patient's journey. We suggested that historical documents were archived, where possible, to make notes easier to navigate.

The standard of care plans in the files we viewed was variable. While some care plans were detailed and personalised, the quality overall was not consistent. The process for care plan reviews was also poor. We found that reviews were often not taking place on a regular basis, and rarely within the timeframes suggested in individual care plans. The service manager acknowledged that improved care planning continued to be an area of focus for the team.

There was a prominent focus on care rounding documentation, which had a strong emphasis on physical health and limited scope for documenting aspects of mental health and risk, such as stress and distressed behaviours. Daily nursing progress notes often had little detail. Nursing staff told us that care rounding documentation was time consuming to complete and, in their view, unless a patient had significant physical health problems it was perhaps less appropriate for monitoring their care. We gave this feedback to the service manager.

We were concerned about a lack of clear detailed risk assessment documentation, especially for patients with significant risk issues. Although relevant information could usually be found on close reading of the case notes, it is important that this information is collated in one document, and that care plans reflect this. Care plans should also offer detailed guidance on managing risk issues for the individual, including observation where required.

We found some inconsistencies in the documentation used to record the same information. Patients' personal histories appeared to be recorded in different

documents in different patient files (Story of My Life, Personal History Profiles or Getting to Know Me forms). Irrespective of which document was used, in the files we viewed personal history information was often incomplete.

Ward round reviews were printed on coloured paper making them easy to find, and these continued to be generally well completed.

We found good use of standardised coloured stickers in progress notes to highlight occasions of as-required medication use, and post-falls top to toe surveys.

When reviewing prescription kardexes we noticed that each patient had an ID check form, to be signed every time medication was administered. These forms had not been updated in the weeks prior to our visit. We highlighted this with senior staff.

Some patients had do not attempt cardiopulmonary resuscitation (DNACPR) forms, which had been completed prior to their transfer to Lammerlaw Ward. On occasion forms were out of date, and required review.

#### **Recommendation 1:**

Managers should carry out a review of all documentation to consider the most appropriate formats for recording aspects of patient care, such as personal history, care planning, and risk assessments, to ensure standardisation across the unit.

#### **Recommendation 2:**

We repeat our previous recommendation that managers should carry out regular audits of case files. Particular attention should be given to ensuring there are person-centred care plans, life history information, and comprehensive risk assessments completed for every patient. Audits should also ensure that DNACPR documentation is up to date.

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

At the time of our visit two patients were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003. Copies of documentation were accessible on file.

Many of the patients we reviewed were subject to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act). Patient notes sometimes indicated the adult had a power of attorney, but copies of documents confirming this, and detailing the welfare powers in place, were only present in one of the case notes we reviewed.

When an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law, and provides evidence that treatment complies with the principles of the AWI Act.

On this visit we found examples of s47 certificates requiring renewal. We advised the staff of this on the day.

### **Recommendation 3:**

Managers should ensure that all patients receiving treatment under the AWI Act have up-to-date section 47 certificates to authorise their medical treatment. They should be accompanied by personalised treatment plans.

### **Rights and restrictions**

We were pleased to hear of links with the local advocacy service. We were told that advocacy support could be accessed by referral, and was being used by families who had relatives on the ward at the time of our visit.

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

This can be found at <https://www.mwcscot.org.uk/rights-in-mind/>

### **Activity and occupation**

When we last visited the ward, a number of carers raised concern about the lack of stimulation and activities available for patients. This had been exacerbated by staff absences.

We were pleased to receive feedback from carers since the last visit that this had improved. We met with the activity co-ordinator, and heard about the activity programme that is currently running in the ward.

The activity co-ordinator and assistant mainly run small group activities and outings, in addition to one-to-one sessions. Current weekday activities for the whole patient group include music therapy, craft sessions, and regular visits from a group of children from a local nursery.

We were told that a relative had raised funds for the ward to arrange drama sessions, and that links were being made with the local library to start Living Voices reminiscence sessions.

The activity co-ordinator told us about risk assessment paperwork they had recently been designed for patients engaging in the activity programme and going on outings. This seemed a positive initiative, and we suggested that managers support the activity co-ordinator to join the local activity documentation group set up by their peers.

We heard of challenges in maintaining the activity programme, as staff were also required to support the nursing team with daily aspects of patient care. Issues of

additional training needs were raised with us, regarding the skills required for some aspects of this care. We discussed this with managers on the day.

### **The physical environment**

Although many steps have been made to improve the ward environment in recent years, the original fabric of the building, and its dormitory-style layout, make it ill-suited to providing specialist dementia care.

Staff highlighted particular difficulties with observation on the ward in the current configuration. The new unit has been designed specifically for the patient group, and we are told it will provide an open-plan, dementia-friendly environment, with facilities including en-suite accommodation for every patient.

We look forward to visiting the new unit when the service is relocated.

### **Summary of recommendations**

1. Managers should carry out a review of all documentation to consider the most appropriate formats for recording aspects of patient care, such as personal history, care planning, and risk assessments, to ensure standardisation across the unit.
2. We repeat our previous recommendation that managers should carry out regular audits of case files. Particular attention should be given to ensuring there are person-centred care plans, life history information, and comprehensive risk assessments completed for every patient. Audits should also ensure that DNACPR documentation is up to date.
3. Managers should ensure that all patients receiving treatment under the AWI Act have up to date section 47 certificates to authorise their medical treatment. They should be accompanied by personalised treatment plans.

### **Service response to recommendations**

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

ALISON THOMSON  
Executive Director, Nursing

## **About the Mental Welfare Commission and our local visits**

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

**Contact details:**

**The Mental Welfare Commission for Scotland**  
**Thistle House**  
**91 Haymarket Terrace**  
**Edinburgh**  
**EH12 5HE**

telephone: 0131 313 8777

e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

