

Left Behind

Report on our visits to
people with severe and
enduring mental
illness in 2011

“LEFT BEHIND”

OUR VISITS TO INDIVIDUALS WITH SEVERE AND ENDURING MENTAL ILLNESS: APRIL-JULY 2011

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 the Commission monitors individual care and treatment is through our visits programme. We visit individuals in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment are

being delivered. As part of this programme we carry out at least three national themed visits each year. The aim of national themed visits is to enable us to assess and compare care and treatment for particular groups of individuals across Scotland. Our aim is to help services learn from good practice and to respond to any issues that are identified.

This report reflects our findings from a programme of visits that took place across Scotland between April and July 2011 to individuals with severe and enduring mental illness in rehabilitation and continuing care wards based in psychiatric hospitals across Scotland.

WHY WE VISITED

The present report returns to the services that we visited in 2008. Our findings and recommendations from the visits in 2008 are included in our publication *Greater Expectations Revisited*. That report set out our concerns about:

- **Locked doors**

Many of those we visited had to negotiate locked doors in wards. Individuals were often unable to control access to their own personal space, having to seek out staff assistance to unlock doors.

- **Feeling safe**

A majority of those we saw in 2008 had been threatened or subject to aggression by other patients. We believe that individuals should feel confident that they can ask for help, receive support and be informed of outcomes following such incidents.

- **Admission criteria for wards**

We found that individuals with widely varying needs were placed together in rehabilitation and continuing care wards. This presented enormous difficulties for staff and was not supportive of individual recovery.

- **Meaningful activity**

We found that, while opportunities for activity and recreation were improving, for some there was little evidence of provision of meaningful, individualised programmes.

- **Physical healthcare**

Smoking, diet and exercise were highlighted as areas of concern. Many individuals recognised the problems associated with their lifestyles, but did not feel they were receiving the necessary support to make the changes they wanted, in order to improve their health.

- **Capacity to consent to treatment**

Although nursing staff were generally aware of matters of consent in relation to those subject to compulsion under the Mental Health Act (2003), there were issues of general consent to treatment and a lack of awareness of the Adults with Incapacity Act (2000).

We felt it was time to revisit these continuing care and rehabilitation wards in order to evaluate the progress made since 2008.

HOW WE CARRIED OUT THE VISITS

Between April and July 2011 we visited all of the mental health rehabilitation and continuing care wards across Scotland. Appendix A provides a list of wards we visited during 2011. We identified a total of 354 individuals receiving care and treatment in those wards. We met, or examined case notes of, 144 individuals (41% of all in those wards) receiving care in 36 wards across 21 sites. Due to closures and reconfiguration of services, this was a reduction from the 45 wards and 159 individuals we visited in 2008. Appendix B gives details of the individuals we visited.

Our visits were announced in advance so that individuals who had particular concerns could arrange to meet us. We also asked individuals we met on the day if they would be willing to share their experiences with us by answering some prepared questions. Many individuals were unable to answer all of the questions, responding instead to those of most relevance or interest 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 about the individuals currently in the ward and about how their care and treatment was provided. Where possible, we met relatives and carers who happened to be in the ward at the time or had requested a meeting with us.

In addition, we examined individual case notes in each ward to look at the care being delivered and how this is recorded. We also looked at the environment of care in these wards.

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 individuals told us form the basis of the findings in this report.

WHAT WE EXAMINED

We focussed on the following areas when we carried out our visits:

- Privacy, dignity and identity
- Administration of medication
- Safety
- Participation, care planning and consent
- Quality of the environment
- Activities and management of funds
- Physical healthcare; smoking, diet and exercise; and consent to treatment

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The individuals we visited had severe and enduring mental illness. Their needs for care and treatment are among the highest of all we meet in the course of our work. Community services have not been able to meet their needs. Many will continue to need care in a safe and highly supported residential setting.

We had serious concerns about their care.

- Almost half did not have an individual activity plan tailored to their needs.
- Many were subject to unnecessary restrictions because of blanket policies.
- Many felt unsafe and did not feel that staff acted on their concerns.
- We were not convinced that enough was being done to check their physical health.
- Some were still being subjected to the outdated and institutional practice of queuing for medication.
- We found that most of them were living in environments that were poorly decorated or maintained.

We fully support the drive to shift the balance of mental health care toward community services. We find it unacceptable that those with the highest needs are being left behind in poor accommodation. They need more access to services that promote recovery. We identify key messages in this report to draw attention to the high level of unmet need in those who remain in hospital on a long-term basis.

There were some positive findings in this report. There were improvements since the last themed visit to these wards in 2008. We found:

- Fewer were sharing a room, far fewer had concerns about a safe place to keep personal possessions, fewer bedroom doors were locked, and privacy in toilet and bathroom areas appears much improved.
- A majority of those interviewed said they felt they could make a complaint. Many were happy that staff dealt with their complaint satisfactorily.
- More individuals told us they had been given information about their illness, treatment and medication. Many had family/ partner or friends involved in their care where appropriate and also said they could influence who attends the review meetings. A majority said they were able to look at a copy of their care plan if they wanted to.
- Almost everyone interviewed said they had been offered independent advocacy services, a significant increase on 2008.
- A higher percentage said they had a named nurse they could talk to about their care and treatment.
- In many areas, programmes of self administration of medication demonstrate good practice in helping individuals progress towards discharge.
- Individuals appear to be getting more help with diet, exercise and stopping smoking.

KEY MESSAGES

We have developed the following key messages so that NHS Boards, hospital managers, clinical and professional leaders and others can use them to consider the care they provide and make improvements where necessary.

Key Message 1

Because of ward closures and mergers, individuals with very different needs have been placed together in the same ward. Decisions made regarding free access to areas of the ward, or to the ward itself, may therefore reflect risk associated with a minority, restricting freedom of movement of the majority. Restrictions on freedom should be based on individual need and must not be applied on a blanket basis.

Recommendations: NHS Boards should

- Review the needs of individuals in relation to the intended function of the ward with the specific needs of those in rehabilitation and continuing care wards taken into account.
- Ensure that wards designated to facilitate rehabilitation promote independence by providing an environment free from unnecessary constraints and locked doors.
- Evaluate whether treatment programmes reflect assessed need and help to promote recovery.

Key Message 2

The practice of queuing for medication, where this is for the convenience of the service rather than for the benefit of the individual, is degrading and in breach of individuals' human rights and should be stopped.

Recommendations: NHS Boards should

- Ensure the practice of queuing for medication is withdrawn. This routine 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. Wards must provide safe and appropriate ways of administering medication which ensure that individuals are treated with dignity and their privacy respected.

Key Message 3

A significant number of individuals stated that they felt unsafe. Only around half of those who did not feel safe said they felt able to report their concerns to

staff. Even fewer felt that staff had adequately dealt with their reported concerns about safety.

Recommendations: NHS Boards should

- Ensure that individuals have information and are made aware of how to raise concerns about safety issues. They should have access to independent advocacy to assist them in this process.
- Establish procedures to have all concerns fully investigated, recorded and to have outcomes explained to the person who raised them. This will normally be integrated as part of the complaints procedure.

Key Message 4

Individuals are not always being given the opportunity to meet with their doctor on a regular basis, either individually or at MDT meetings, in order to plan and review their care and treatment.

Recommendations: NHS Boards should

- Ensure there is an opportunity for individuals to participate in the planning of their care
- Ensure that individuals can meet with their doctor either one-to-one or at a review meeting according to their wishes

Key Message 5

Some wards are not fit for purpose. This will impact on individual recovery and can adversely affect the ability of staff to provide proper care and treatment.

Recommendations: NHS Boards should

- Set up a programme of refurbishment and redecoration of areas which are unfit for purpose; replacing furniture and equipment which is no longer fit for pur-

pose; and creating more appropriate environments for rehabilitation and continuing care.

- Ensure that newly built units have adequate space within the building and in exterior areas to meet the support needs of individuals living there and their visitors.

Key message 6

Many individuals did not have an appropriate plan for activity. They should have access to activities that meet their individual needs. Moreover, there was little evidence of creative use of their funds to enhance their quality of life.

Recommendations: NHS Boards should

- Ensure that activities are recorded in individual records with clear aims and outcomes identified based on assessed individual needs
- Ensure that activity programmes are fully agreed and that a copy of the programme is retained by individuals themselves.
- Prioritise activities to ensure they remain unaffected by other factors e.g. staff shortages.
- Ensure that there are procedures in place to safeguard an individual's finances; to review benefit entitlements; and to settle outstanding bills.
- Review current arrangements for management of individuals' finances to ensure each person is able to benefit from their accrued funds.

Key Message 7

A record of physical health checks, as required in 'Delivering for Mental Health', is absent in around 25% of case files examined. It is difficult to know, therefore, whether the checks are being carried out or just not being recorded. In some wards, capacity to consent to medical treatment is not being routinely assessed and individuals afforded the appropriate legal safeguards to protect their rights and to ensure that treatment is lawful.

Recommendation: NHS Boards should

- Ensure local hospital policies are in place so that regular physical health checks are carried out for individuals, whether or not they have an identified

illness requiring medical attention. This is especially important in view of their increased risk of physical health problems and potential side effects of medication.

- Ensure there is an accepted and audited process for assessment and review of capacity to consent to medical treatment.
- Identify whose role it is to audit the consent to treatment forms for compulsory treatment of mental disorder under the Mental Health Act (2003) and ensure that this is carried out regularly.

WHAT INDIVIDUALS TOLD US AND WHAT WE FOUND

Privacy, dignity and identity

Key Message 1

Because of ward closures and mergers, individuals with very different needs have been placed together in the same ward. Decisions made regarding free access to areas of the ward, or to the ward itself, may therefore reflect risk associated with a minority, restricting freedom of movement of the majority. Restrictions on freedom should be based on individual need and must not be applied on a blanket basis.

What we looked at

With hospital closures and programmes for the re-provision of services taking place, it is important that individuals who continue to need care and treatment in a hospital are treated with dignity and respect. The environment of care has a major impact on this aim. Ward practices and procedures also contribute to how individuals' rights are respected.

We examined how the environment of care and the ward culture shape individuals' experience of a longer period in hospital, whether it be working towards rehabilitation or staying in hospital on a continuing basis.

We asked staff about the mix of individuals on the wards and whether they felt that someone would be better placed elsewhere. We also looked at the impact this might have on the care of others and any obstacles to individuals moving on.

What we expect to find

We expect that those in hospital wards will be treated with respect and dignity, whether they are there for a short period or a longer stay. Therefore, individuals should be cared for in a setting appropriate to their needs. They should also be subject to the least restrictive environment in relation to their assessed need.

Clinical need, not service expediency, should determine where someone is placed. Individuals should be regularly assessed, reviewed and placed according to the admission criteria and function of the ward.

What we found

There is encouraging evidence of many improvements since the last themed visit to these wards in 2008: the number sharing a room has reduced from 40% in 2008 to 25% in 2011; far fewer have concerns about a safe place to keep personal possessions; and bedroom doors are locked in half as many cases throughout the day. Several wards said that occupants of single rooms have their own keys and can lock their room if they want.

Nevertheless, there remain concerns about restrictions and practices which continue in a number of wards. Staff reported that, although the door to the ward is still locked in 9 of the 34 wards visited, three could be opened by coded key pads and 4 were only locked for purposes of security during night hours.

We had more reports in 2011 from individuals about lack of quiet areas (other than day rooms) and lack of private space for visitors, than in 2008.

The majority of wards visited had a quiet area available to individuals. Many wards had converted a room which had previously been used for a different purpose or had rooms for multipurpose use e.g. dining/ meetings/activities. In some wards, individuals saw visitors in their bedrooms, but these were often described as too small for this purpose. In others, there was a flexible use of activity/quiet/dining rooms for visiting. In many wards, staff identified the areas available for this purpose to be inadequate. There were also comments from MWC visitors about a lack of facilities for children visiting.

The ability to exercise choice in as many areas of daily living as possible is important both for the individual's rehabilitation and in order to adhere to the principles of the Mental Health Act. This choice appears to have increased in many cases since 2008. Very few individuals said they were unable to make private telephone calls; and fewer (around 33%) said they could not make drinks or snacks when they wanted. However, many stated that, due to locked kitchens, they may still first have to ask staff to unlock the kitchen door

One individual visited shares a 2 bed flat with another person of the same sex. She has a key to lock and unlock her room whenever she wants. She can go out of the ward by informing the staff of her whereabouts. The flat also has a kitchen and private lounge which are completely functional, and she has no restrictions on the use of her mobile phone.

However, it was apparent that individuals in newly provided accommodation were no longer able to access the kitchen to do their own cooking. We met managers here and asked that the health board identify an alternative way of providing this essential preparation for a life outside hospital. Furthermore, in another ward, we were told there was no lockable space available for personal use in individuals' bedrooms.

One person visited said that there was limited access to a private telephone. The option was either to use the office phone (not private) or to go upstairs and use the phone outside another ward.

Access to drinking water seems to be marginally better than in 2008, and the majority of individuals were happy with the food. However, there were mixed views about these. One visitor noted that there appeared to be a reliance on restrictive measures affecting the whole ward in response to specific behavioural issues on the part of particular individuals. For example, because of the conduct of one person, there was no free access to drinking water in the ward.

The impact of the behaviour of others on the progress of individuals can be significant. This was highlighted by a visitor to one ward. She saw evidence of individualised and person centred care where staff made efforts to take account of individual needs and to provide choices to women who had been in hospital for a number of years. However, there was concern about the very challenging mix in this all female ward and the impact that this has on both staff and patients.

One person commented about lack of privacy

“One patient comes into the bathroom whilst I am having a pee - not very often. A staff member helps if I'm bathing or showering and will keep other patients away.”

When asked about individuals being inappropriately placed on wards, staff in almost half of the wards indicated that there were individuals who would be better placed elsewhere. One visitor was told by the ward charge nurse that at least 65% of individuals did not need to be in the hospital. He indicated that they should be in supported accommodation but that this was not available at that time. One ward had been closed (and the groups merged) to generate funds for the commissioning, planning and building of new supported accommodation, which was expected to be up and running within around nine months.

In some cases, the inappropriate placement of individuals in wards may have arisen from closures elsewhere. A visitor to one ward witnessed one person, who could have been moved to rehabilitation, but this had not happened because of funding problems. Another person was in the ward temporarily for physical health reasons.

In another area, someone had been moved from a higher dependency unit due to sexual advances to others. This person was very unwell and had the potential to upset other patients due to his behaviour.

Although the obstacles to discharge had been identified in most cases, the inappropriately placed individuals did, according to staff, have an impact on the care and treatment of others. One charge nurse was of the view that the inability to move individuals into supported accommodation was impacting on the quality of care offered to those individuals and others as well, as he believed this resulted in having two different groups with very different needs in one ward.

Recommendations: NHS Boards should

- Review the needs of individuals in relation to the intended function of the ward with the specific needs of individuals in rehabilitation and continuing care wards taken into account.
- Ensure that wards designated to facilitate rehabilitation promote independence by providing an environment free from unnecessary constraints and locked doors.
- Evaluate whether treatment programmes reflect assessed need and help to promote recovery.

Administration of Medication

Key Message 2

The practice of queuing for medication, where this is for the convenience of the service rather than for the benefit of the individual, is degrading and in breach of individuals' human rights and should be stopped.

What we expect to find

It is reassuring to find in rehabilitation and continuing care wards that programmes of self administration of medication are becoming more commonplace. Individuals will find it helpful in moving to a more independent and less supported setting, to have rehearsed the process and become used to managing their medication. Those who require supervision in the administration of medication are entitled to privacy and respect for their dignity.

What we looked at

We asked individuals whether they had to queue for their medication and noted any comments we received from individuals about this issue.

What we found

Many individuals working towards discharge from hospital are able to self-administer their medication. However, some will continue to need supervision with the medication they take for a longer period.

Although most did not cite any problems with the administration of medication, 36% of individuals asked said they had to wait in a queue. This affected individuals in almost 66% of the hospitals we visited. Most who reported this seemed to accept having to queue as normal without questioning the practice. Some individuals spoke about it in negative terms

"I don't like standing in a queue for medication."

"It does take too long for the medicines."

Recommendations: NHS Boards should

- Ensure the practice of queuing for medication is withdrawn immediately. This routine 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. Wards must provide safe and appropriate ways of administering medication which ensure that individuals are treated with dignity and their privacy respected.

Safety

Key Message 3

A significant number of individuals stated that they felt unsafe. Only around half of those who did not feel safe said they felt able to report their concerns to staff. Even fewer felt that staff had adequately dealt with their reported concerns about safety.

What we looked at

We asked individuals if they had felt unsafe during the previous twelve months in hospital. For those who felt unsafe, we asked if they had reported it to staff and whether any action was taken as a result.

What we expect to find

Individuals who are vulnerable due to mental disorder must feel safe in hospital. If concerned about their safety, there should be a way to ask for help and receive support in dealing with these concerns. There should also be a process whereby staff inform the individual what action has been taken as a result and how this will help them to feel safer in future.

What we found

We had concerns in 2008 about individuals who said they felt unsafe. There is still evidence that many do not feel safe in this type of setting. 30% (36) of 118 individuals visited in 2011 said that they had felt unsafe on the ward in the past year.

It is not always clear what makes individuals feel unsafe. In general, there was a reluctance to discuss specific incidents. One woman said she felt safer in a female only dormitory than when she was in an area with four single bedrooms of mixed sex.

A small minority said that they had reported incidents to staff. Whilst there were many who felt satisfied that they had been listened to and that action had been taken, in one case

“Sometimes you get dismissed if you ask for something from staff. They might be busy - but it happens a lot.”

Nevertheless, many felt that staff dealt with concerns satisfactorily. Just over 50% of all individuals interviewed said they felt they could make a complaint. Only just over 25% said they had ever made one. One person was satisfied with the handling of his complaint. He told staff about an individual who was harassing him verbally and felt they dealt with it well. He does not know what they did but the patient stopped harassing him. Therefore, although the person was satisfied with the outcome, he does not appear to have been given information about what staff did.

As the above example shows, feeding back to individuals the outcome of action taken by staff remains problematic. In one case, the person said he had been bullied in the past but did not want to talk about it. He would only say that he did not feel staff did anything about it and did not give him feedback.

From the comments made about safety, it is clear that some individuals recognised that the behaviour of others and fears they felt were part of their illness. Eleven comments referred to specific incidents or aspects of the ward which made them feel unsafe. These included the following:

“A couple of other patients shout at me sometimes - one bit me and injured me in the past in another ward, so I’m wary of her. I always tell staff and they speak to them and deal with it.”

“I’m not sure that staff do much to intervene to protect others if someone is disturbed or interfering.”

Whilst a few individuals said they would not report incidents because of lack of trust in staff, there were also those who felt staff were approachable and would do what was necessary to reassure them.

“Staff acted and the person (staff member) I complained about no longer works with me.”

“I spoke to an advocacy worker. The complaint was dealt with satisfactorily.”

Recommendations: NHS Boards should

- Ensure that individuals have information, and are made aware of how to raise concerns about safety issues. They should also have access to independent advocacy to assist them in this process.
- Establish procedures to have all concerns fully investigated, recorded and to have outcomes explained to the person who raised them. This will normally be integrated as part of the complaints procedure.

Participation and care planning

Key Message 4

Individuals are not always being given the opportunity to meet their doctor on a regular basis, either individually or at MDT meetings, in order to plan and review their care and treatment.

What we looked at

We asked how much information individuals were given about their illness and the treatment of it. In addition, we looked at their involvement in decisions about their care and how information was exchanged.

What we expect to find

We expect that individuals will be given information about their illness and that they will be involved as far as possible in decisions about their care. Views of individuals and other interested parties should be taken into account with respect to care and treatment and issues causing concern.

What we found

Around 65% said they had been offered information about their illness and a similar proportion had attended review meetings. About the same number felt that they had been able to have a say in their care and treatment. An even higher percentage had been given information about their treatment, including their medication. More than half had family/ partner or friends involved in their care, where appropriate. A similar number said they were able to look at a copy of their care plan if they wanted to. Around 65% said they could influence who attends the review meetings. It is worth noting that, of those who did not answer 'yes' to these questions, quite a large proportion said 'don't know'.

Some evidence of good practice in individual participation in their care was noted. One person said that his named nurse discussed reports with him before reviews of his treatment plan and he always got the chance to put his views forward.

Another said that there were weekly meetings. He could write on a form any issues that he wanted to be considered by the Multi Disciplinary Team. He also attended review meetings monthly.

In another hospital, the named nurses met individuals at least weekly and the person was able to discuss his weekly programme and any other issues. He also attended monthly and three monthly reviews.

Another individual was reported to be very reluctant to get involved and refused to sign a care plan. The named nurse made great effort to talk to him about plans. He stated that the individual required coaching to the point where he was able to communicate, otherwise he became aggressive and his mental state could be made worse.

There were also reports of some practice which fell below what we would expect. One person stated that he only saw the doctor once a year. He did get information about his illness from other staff. However, he was unclear how decisions about treatment were made. The issue of involvement and participation was followed up with the service in this particular case.

Another individual recounted that meetings could be intimidating

"I have reviews every 3 months or so. Sometimes there are too many people in the room firing questions."

Interestingly, there was greater evidence of participation recorded in case files of detained individuals (70%) compared with those admitted on a voluntary basis (46%).

Case file reviews indicated that those detained in hospital (89%) had more evidence of a holistic assessment of needs than those in hospital on a voluntary basis (58%). Not all experiences of planning care were positive. One person had only attended a multidisciplinary meeting twice since admission to the ward over one year ago.

Another person did not like reviews because they made him feel anxious. He said he would like the option of meeting with the doctor outwith review meetings. He was offered a 1:1 meeting, but with different staff (ie not always same member of staff). He subsequently decided that, in the absence of having a choice of how to be involved

"I keep things to myself."

With regard to seeing a copy of a care plan, one visitor noted that one individual had difficulty retaining information given verbally. She thought that having a written copy of her care plan in this case would be useful.

Almost everyone has access to independent advocacy compared to around 65% in 2008. A higher percentage than in 2008 said they had a named nurse they could talk to about their care and treatment. The frequency of meetings varied between daily and monthly, with many individuals reporting that they are able to meet on request. For meetings with a key worker, the most frequent response (76%) was a weekly meeting. For consultants, a similar percentage saw individuals at least monthly.

"I can ask the doctor or key nurse any questions but I am happy with the way things are."

Recommendations: NHS Boards should

- Ensure there is an opportunity for individuals to participate in the planning of their care
- Ensure that individuals can meet with their doctor either one-to-one or at a review meeting according to their wishes.

Quality of the environment

Key Message 5

Some wards are not fit for purpose. This will impact on individual recovery and can adversely affect the ability of staff to provide proper care and treatment.

What we looked at

We looked at the environment to see if it was fit for purpose and remains suitable for care and treatment of individuals with higher needs and who have often spent long periods in hospital.

What we expect to find

We expect to find accommodation that affords an adequate degree of privacy and that has been kept in a good state of cleanliness and repair. The environment should have the necessary facilities to offer appropriate programmes of rehabilitation or continuing care.

What we found

The vast majority of individuals interviewed felt that their ward was kept clean and free from odours. Although clean, however, around 65% of wards were described by visitors as poorly decorated or maintained. In one ward there was no flooring in one corridor. Paintwork was tatty with holes in walls in need of repair.

However, a few examples were found to be well provided. A visitor noted

The ward was clean and bright with lots of areas for people to move around in and benefitted from the reduction in bed numbers.

It is clear, therefore, that differences can be made

One visitor reported

The individuals we spoke to were very appreciative of the huge improvement in their physical surroundings, as many had come from wards where environmental facilities had been very limited. Staff had invested time and effort in making this a very useable space with patio areas, a smoking gazebo, rockery, herb garden etc. They had involved patients in selecting and planting pots and a number of quite 'difficult to engage' individuals were beginning to get involved and enjoy gardening activities. Ailsa Hospital

Other comments on positive change included

Rehabilitation is offered in a unique setting that very closely resembles a community placement.

There appeared to be fewer concerns about noise levels, ventilation, access to garden space and the condition of toilet/ bathing areas.

Recommendations: NHS Boards should

- Set up a programme of refurbishment and redecoration of areas which are shabby, replacing furniture and equipment which are no longer fit for purpose and creating more appropriate environments for rehabilitation and continuing care.
- Ensure that newly built units have adequate space within the building and in exterior areas to meet the support needs of individuals living there and their visitors.

Activities and management of funds

Key message 6

Although many had individual activity plans, almost as many had no plan or were engaged in activities unrelated to assessed need. Moreover, in some wards, individuals experienced disruption to daily activity routines, or were able to access only a limited range of activities. There was little evidence of creative use of their funds to support the person, nor of savings being used to enhance quality of life. This was not seen as being an important part of the duties of health care staff nor was it discussed during care reviews.

What we looked at

We asked how individuals spent their time in terms of structured activities and recreational pursuits. We looked to see if there were programmes of activity and whether people had their own copy of an individualised activity programme. We also looked at facilities available and who had responsibility for the organisation of activities. Finally, we asked about the management of individuals' funds and how this could be of benefit to each individual.

What we expect

We would expect all staff to share responsibility for ensuring there is a culture that promotes and includes activity for individuals in all aspects of their daily life. We would expect individuals to be free to engage in personal and social activities that respond to their needs and interests in a relaxed and friendly environment.

We would expect the range of activities for each individual to reflect their choice, their social, cultural and religious preferences, and to be available at frequent and regular intervals throughout the week.

Individuals should receive their full entitlement to benefits and the management of their money should be in line with the principles of the Adults with Incapacity Act, i.e. it is being used for the benefit of the person, in a manner that maximises their skills and in the least restrictive way.

What we found

There was evidence of good practice in the provision of activities in many areas. One visitor noted individuals who were planning meals, shopping, doing their laundry and managing their own finances, where appropriate. The weekly programme was discussed with individuals and drawn up with their input on a weekly basis. In another area, the visitor was very pleased to note that there were plans for developing both rehabilitation outreach services and a day care service and felt this would add to the strength of the rehabilitation service and increase flexibility and fluidity between hospital and community care.

From the case notes check we found that only 49% of those we visited had an individual activity programme. A similar percentage told us they had their own timetable recording what they did each week.

There was some disparity in the provision of activities by hospital. Some wards were able to arrange individual programmes for all. Others only did this for a minority of individuals.

There were also areas of poor provision. In one hospital, the visitor noted that activities were proving difficult to provide in the wards, with the activities nurse being on long term sick leave, and with nurses in the wards struggling to organise activities because of the level of clinical duties undertaken.

In another hospital, visitors could find no evidence of a varied and structured programme of activities in the ward. Nor was there evidence of any activities taking place for most of the individuals visited.

Five wards were noted as not having dedicated space for activities. Three of these wards, nevertheless, had individual activity programmes. According to staff interviewed, all but one ward arranged outside activities.

In one ward, to ensure individuals' opinions are heard, community meetings and the use of daily diaries were used to encourage individuals to have ownership of their participation in activities.

In all hospitals there were formal systems to manage individuals' money under AWI part 4. We heard that there are regular procedures for review to ensure that opportunities to use individuals' funds to enhance their quality of life in all hospitals. Unfortunately, there were a number of individuals who have accumulated large amounts of money, where the funds are not being spent in ways to attempt to improve their quality of life.

Some residents had significant amounts of savings from being in hospital care for many years or as a result of an inheritance. One person who had considerable savings accumulated from their time in hospital was paying for a support worker to enable them to get out on individual activities. Others saved from their personal allowance and the mobility component of their Disability Living Allowance. Money was spent on clothes, toiletries, taxis and social and recreational activities. Some saved for holidays. Others had not been on holiday for some years. Some individuals with larger amounts of savings had benefitted from specialist equipment.

However, not everyone was benefitting from the arrangements. A visitor noted

One individual we met has her finances managed by the hospital and was very unhappy about this. She was someone who appeared very capable in basic skills, and in most other areas of decision making, and it was clear that this measure is being taken because of a particular vulnerability. However, there is no care plan in place for this measure, and no evidence of any plan to support her in regaining financial independence. In the absence of any systematic review, she does not know what she needs to do to regain more financial freedom, nor can she effectively challenge this action.

Moreover, action which should have been taken to protect an individual's interests had not been taken. In one hospital, a visitor commented

Two of the five individuals visited had amassed council tax arrears and DSS overpayment respectively, and these had accumulated over a long period of time ... any debt that accrued as a result of a long hospital stay should have been dealt with as soon as possible in the person's admission.

Recommendation: NHS Boards should

- Ensure that activities are recorded in individual records with clear aims and outcomes identified based on assessed individual needs
- Ensure that activity programmes are fully agreed and that a copy of the programme is retained by individuals themselves.
- Prioritise activities to ensure they remain unaffected by other factors e.g. staff shortages.
- Ensure that there are procedures in place to safeguard an individual's finances; to review benefit entitlements; and to settle outstanding bills.
- Review current arrangements for management of individuals' finances to ensure each person is able to benefit from their accrued funds.

Physical healthcare; smoking, diet and exercise; and consent to treatment

Key Message 7

A record of physical health checks, as required in 'Delivering for Mental Health', was absent in around 25% of case files examined. It is difficult to know, therefore, whether the checks are being carried out or if they are just not being recorded. In some wards, capacity to consent to medical treatment is not being routinely assessed and individuals afforded the appropriate legal safeguards to protect their rights and to ensure that treatment is lawful.

What we looked at

We asked individuals about their general health, about treatment they had received for this and also about diet, exercise and assistance to stop smoking. We looked for documentation to authorise treatment for those subject to mental health legislation and those who lacked capacity to consent to treatment.

What we expect

Individuals who are in hospital for lengthy periods should have physical health checks on at least an annual basis. Individuals should also be supported to access the same screening programmes as people living in the community.

The Scottish Government's "Delivering for Mental Health" (2006) requires, where possible and appropriate, that every individual with severe and enduring mental illness has a physical health assessment at least once every 15 months.

Capacity to consent to treatment should be assessed and regularly reviewed and legal safeguards put in place to authorise treatment. Where legal documentation has been completed, it should be accessible to staff administering treatment and systems should be put in place to ensure it continues to be lawful.

What we found

In one hospital, we were told that physical health checks were done at least annually, but we could find no evidence in case notes of several of the individuals whose care we examined. We had similar concerns in respect of dental care. We met one woman who has an immediately obvious tooth loss. We were told that although she was registered with a dentist, no one knew whether she had had any restorative work done or had been offered a dental appointment.

In another hospital, the visitor heard that the GP attended every day and responded to nurses' requests to see individuals. Nurses ran a 'health care clinic' every Monday morning, took blood samples, monitored blood pressure and administered ECGs. However, there was no evidence of regular GP health checks.

The proportion of smokers in the group we visited had not changed since 2008 (around 70%). There was, however, an improvement in the proportion of smokers - from 50% in 2008 to 76% in 2011 - who said they had been offered help to stop.

Concerns about weight were expressed by a similar proportion as in 2008 (around 33%). Comments from visitors indicate that some individuals did have weight problems which they did not acknowledge. Just over half of those who answered the question said that they had had help to manage their weight (this includes some who said they were not concerned about their weight). Again this was not markedly different from 2008. [NB questions were asked differently so responses are not directly comparable.]

63% of those who responded said that they exercised regularly. This question was not asked in 2008. 32 out of the 36 wards responding said that they provide support for physical exercise. Our visitors noted that 'adequate space, equipment and a suitable environment to support activities' was present in 27 out of 31 wards visited.

All but one ward said they had a system for ensuring that individuals subject to compulsion under the Mental Health (Care and Treatment)(Scotland) Act 2003 have a valid T2/T3 consent to treatment form where this is required.

In one ward, where a recent unannounced visit by the Mental Welfare Commission to review treatment certificates had found very poor practice, we were pleased to see some progress:

.... the ward has now improved a lot in terms of monitoring the treatment certificates. The treatment forms are now kept with the drug kardex (with a sticker on the kardex) and in the patients' notes. The treatment certificates are also audited regularly to make sure that they are up to date and also to make sure that the prescribed treatment is properly authorised.)

The full report of our unannounced visits to wards can be found in the Mental Welfare Commission report.

In only 21 out of 36 wards, did staff confirm they had an agreed method for recording consent to treatment for informal patients. Most of them were using medical notes, care plans or ICP forms for this purpose.

Overall, there were more positive answers from staff to the question about S47 certificates being in place in 2011 (67% compared with 50% in 2008).

More generally, 24 of 36 wards described a reasonable way of keeping 'capacity in respect of decisions regarding treatment' under review. However, 34% of individuals, for whom it would have been appropriate, did not have an assessment of their capacity recorded. In some wards staff said it was not an issue, the staff member did not know or there was no system in place to record this. For example, one visitor wrote:

I was told that nurses and doctors are in regular dialogue with the patients about the medication, but there was no record of it anywhere in the case notes I looked at.

Recommendations: NHS Boards should

- Ensure local hospital policies are in place so that regular physical health checks are carried out for individuals, whether or not they have an identified illness requiring medical attention. This is especially important in view of their increased risk of physical health problems and potential side effects of medication.
- Ensure there is an accepted and audited process for assessment and review of capacity to consent to medical treatment.
- Identify whose role it is to regularly audit the consent to treatment forms for compulsory treatment of mental disorder under the Mental Health Act (2003) and ensure that this is carried out.

Conclusions and Further Action

This is the third time we have produced a detailed report on the care and treatment of individuals with severe and enduring mental illness who need lengthy spells in hospital. We have seen some improvements in their care. While this is encouraging, there are still many findings of great concern:

- It is not acceptable that individuals feel unsafe and are still subject to some institutional practices.
- It is not acceptable that nearly half of those we met did not have an individual activity plan tailored to their needs.
- It is not acceptable that most wards are poorly decorated and maintained.

The key messages in this report are designed to make services aware of concerns identified in our visits to rehabilitation and continuing care wards. We expect that those involved in the strategic planning of services as well as staff working in these areas will bear them in mind and respond effectively in providing services which promote recovery and are accessible on a local basis. We will continue to visit individuals in these settings. We hope to see significant improvements.

The Scottish Government should take careful note of our findings. At the time of writing, the Government is consulting on a revised mental health strategy. The strategy must not forget the needs of those left behind in continuing hospital care.

Appendix A

List of wards we visited during 2011

NHS Board	Hospital	Ward
Ayrshire and Arran	Ailsa	Cloncaird, Dean, Killochan/
Borders	NHS Borders	East Brig
Dumfries and Galloway	Crichton Royal	Lahraig
Fife	Stratheden	Dunino, Falkland, Lindores, Eden-
Forth Valley	Bellsdyke	Trystview, Trystpark, Russell Park
Grampian	Royal Cornhill	Dunottar, Fyvie, Polmuir Road
Greater Glasgow & Clyde	Stobhill	Orchard 2
Greater Glasgow & Clyde	Gartnavel	Kelvin and Clyde
Greater Glasgow & Clyde	Dykebar	Wards 4
Greater Glasgow & Clyde	Leverndale	Ward 2 and Rehab
Greater Glasgow & Clyde	Parkhead	Phoenix House
Greater Glasgow & Clyde	Ravenscraig	Corlic C
Highland	Argyll and Bute	Tigh na Linne,
Highland	New Craigs	Aonach Mor, Bruar, Morlich
Lanarkshire	Beckford Lodge	Beckford Lodge and Caird House
Lanarkshire	Coathill	Glencairn
Lothian	Royal Edinburgh	Swanston, North Wing, Craiglea,
Lothian	St Johns	Pentland Court
Tayside	Murray Royal	Gleneig

Appendix B

Individuals visited by age group and sex

Age group	F	M	All
18-24	3	5	8
25-44	19	36	55
45-64	27	43	70
65-84	5	6	11
All	54	90	144

Individuals visited by legal status

Status	no.
Informal	50
detained	94
All	144

Number of beds, number of people occupying beds, and number interviewed

Hospital	Beds	Occupied	Interviewed
AILSA	42	35	13
ARGYLL AND BUTE	11	10	9
BECKFORD LODGE	12	12	3
BELLSDYKE	74	58	15
BORDERS NHS	16	16	3
CAIRD HOUSE	10	10	4
COATHILL	12	12	2
CRICHTON ROYAL	14	14	6
DYKEBAR	20	20	5
GARTNAVEL ROYAL	18	18	5
LEVERNDALE	35	29	7
MURRAY ROYAL	13	11	7
NEW CRAIGS	28	25	7
PARKHEAD	8	8	4
RAVENSCRAIG	16	15	4
ROYAL CORNHILL	50	40	11
ROYAL EDINBURGH	76	65	14
ST JOHNS	12	12	4
STOBHILL	24	24	6
STRATHEDEN	90	77	15
All	591	354	144