Unannounced Visit Report 2005

mentalwelfare commission for scotland

Our impressions of mental health acute admissions wards in Scotland

We believe that good mental health care requires respect for those in need of help and care

Introduction

On the evening of March 7th, the Commission paid simultaneous visits to 20 mental health acute admission wards across Scotland. This report provides a snapshot of what we found in 20 out of 74 such wards. Here we set out what we saw and what the people we met thought about the services they were receiving or working in. We give our impressions, and those of the people we spoke to, of the quality of the environments that people experience while living in hospital.

We believe that good mental health care requires respect for those in need of help and care. Good care requires expert interventions and an environment that promotes well-being. Staff need the time and resources to help people in their journey towards recovery. We also believe that services must actively engage with the relatives and carers of those in contact with services. This report on what we heard and saw is presented against the background of these beliefs.

Who we are

We are 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 law.

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

What the Commission does

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We 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 mental health and learning disability 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 is being applied. We use that information to promote good use of these laws across Scotland.

What is an acute admission ward?

Admission wards in mental health hospitals are intended to provide short-term care to people who require acute psychiatric support. This support may be in response to an emergency, where an immediate response is necessary because of a risk of harm. An admission to hospital is most likely to include assessment, sometimes with initially high levels of supervision and observation. Admission may also be necessary for the supervision of particular forms of treatment. Acute admission should form part of a range of responses and services to help people with mental health problems with support towards recovery[1].

In Scotland, a typical acute admission ward has around 25 beds and serves a particular geographic area. The ward should be integrated into community services that provide a range of interventions and supports for people who have a mental illness.
In any acute admission ward there are likely to be people who are very unwell and some who are further on the path to recovery.

What is also very likely is that those people have a wide range of needs.

It is a major challenge for staff to provide treatment to a group of people and to fully take into account their diverse needs. Some services are exploring new models of nursing care, such as the Tidal Model. Approaches such as these aim to help people with mental health difficulties find their way to regain control over their lives. Many people have discussed alternatives to the acute admission model currently prevalent in Scotland. Those alternatives often involve smaller units, dealing with a narrower group of people with similar needs, operating within a system of support and crisis intervention that reduces the need for admission to hospital.

We believe that no matter how an acute admission service is organised it should provide an environment that is pleasant, where people feel safe, where their dignity and privacy are respected, where their individual needs can be met and recovery is promoted not impeded.

Why did we carry out this visit?

It has long been recognised that acute admission wards have problems. Poor environments, pressure on beds and overstretched staff have been often reported in England. We have heard of and seen similar difficulties in Scotland.

The Commission is no stranger to all of the 74 acute admission wards in Scotland. We carry out at least one announced visit to each ward every year and we make around 500 individual visits a year to people who are on a section and unhappy about their detention. However, experience has taught us that unannounced visits give a very good opportunity to meet people living in these wards and units and hear from them what it is like to be there. An unannounced visit gives a snapshot of how a ward is operating and what conditions are like there. It allows for information to be brought together to give a broader picture across the country and identify common themes.

[1] www.srn.org.uk

This was not an inspection set against formal standards, inspection is the remit of organisations other than ourselves. However our visit programme did give an opportunity for independent visitors to form impressions of what conditions were generally like in places where very ill and distressed people come for help towards recovery.

How did we carry out this visit

All of the visits took place on the evening of 7 March 2005 at 6.00pm. Two or more Commission representatives visited each of the 20 wards listed in the tables of findings (with the exception of Argyll and Bute Hospital where there was one). We requested the nurse in charge tell the patients and any visitors in the ward that the Commission were visiting and ask if anyone wished to speak to us.

We also spoke informally with patients and staff in the wards. We asked patients a number of questions about their experience of the ward. We looked around the places we visited and asked people to show us where they slept and spent the day. We asked the nurse in charge at the time of our visit a number of questions about the service and about any concerns that they had.

How this report is set out

Firstly, we discuss what the patients we spoke to told us in individual interviews. We then offer additional comments from the information that we gathered from staff. Inevitably some of this information is linked and we use what patients told us to illustrate some of the issues that arose from our information gathering from staff. We set out our key messages at the end of the report.

What service users told us

We spoke to 80 people who had been in hospital for varying lengths of time. Some were newly admitted and some were very familiar with the wards that they were in. Our questions largely focussed on quality of life issues – what is it like to be living in an acute admission ward? The good news is that the people we spoke to were generally positive about staff, although we were very struck, as often before, by the generally low expectations of the quality of life that could be expected in an acute ward setting. The responses we received from the patients we spoke to during the visit are set out in detail in appendix 1. Among the comments from service users were:

I like my doctor, he has been very helpful.

Staff are fantastic – A member of staff brought me in flowers for me to give to my mother on Mother's Day so she would be no different from others"

I've been in the ward for 7 days and have only seen a doctor for 10 minutes

A disproportionate number of women living in acute admission wards do not feel safe

Quality of the environment

We asked questions about the environment of the wards where patients were living. Nearly 90% of people interviewed thought their wards were kept clean, a figure that surprised us as our observations were that many of the wards we saw were dull, drab and smoky. Over 40% thought their ward was crowded with just over 50% saying that the temperature and ventilation were not adequately controlled. At the same time around a quarter of patients thought the division between smoking and non-smoking areas was inadequate. Well over half thought their wards were noisy. Around 40% of patients told us that they did not have easy access to a garden area, which limited their opportunity to get access to fresh air or escape from a noisy environment.

Safety, privacy and dignity

A significant number (15%) of patients told us that there was insufficient privacy in toilet and bathroom areas. A number of patients said that staff did not take enough care to respect privacy.

"The member of staff unlocked the door of bathroom to show me the facilities. Someone was using the bath – apparently there is a sign that can be stuck up with sticky tape saying that the bathroom is occupied but it wasn't there".
Commission visitor

Nearly a quarter of patients said that there were no single sex areas (apart from dormitories) in the wards. Over 80% of patients said that they felt safe on the ward. However, of the 17% of people who said they did not feel safe nearly all were women. Of the 76 people who completed our questionnaire 48 (63%) were female, this means that a disproportionate number of women living in acute admission wards do not feel safe (27%).

Information and communication

While staff in all of the wards we visited reported that there was written information available for patients, only around half of the patients we spoke to had received any. As part of an admission process people need to know why they are being admitted to hospital, what will be happening and what treatment they may be receiving. The arrangements for seeing doctors and named nurses and for holding case conferences needs to be clear as does information about activities, shops and visiting. Admission to hospital can be confusing and bewildering with much to take in. Some services provide excellent information. The Royal Edinburgh Hospital provides every patient with a loose leaf folder that contains information about a stay in hospital. Other services have leaflets on a variety of topics.

We were struck by the contrast in the amount and quality of information that is available to patients across Scotland.

Information is only effective if it reaches the people for whom it is intended. We were disappointed that a great many patients are less informed than they should expect to be.

We also noted that all but two hospitals (Ailsa and Monklands) had information available for relatives. Although we did not ask a specific question, we were told by many of the people we visited that they had not received written information about their medication. However, the Crichton Hospital does give details of how to contact the clinical pharmacist for information. We think this is an example of good practice.

Some patients and staff mentioned to us the disruption caused by difficulties in the recruitment of psychiatrists. In the Highlands, chronic recruitment difficulties have led to the extensive use of locums with the associated difficulty this brings to continuity of care and communication between doctor and patient.

There were 240 patients in the 19 wards we visited. 13 were from an ethnic minority group and 8 of those did not speak English as a first language. Reassuringly, all of the wards reported that there was access to an interpreting service. However around 50% of the wards did not have written information in the language of the patients from an ethnic minority or in any language other than English (see table on page 6). Access to an expert independent interpreter is essential for assessment and the provision of treatment. Written information is also essential to ensure that the person who does not understand English is equally informed about their care and the service in which they are receiving treatment as someone who does.

Services should review their written guidance information to make sure that it is available, as far as practicable, in the languages of the people who receive treatment in their hospitals.

Keyworkers and named nurses – valued but often not available

Just over 70% of the patients we spoke to were aware that they had a keyworker or named nurse. However, of those who were aware that they had a key worker, many commented that the staff appeared to have little time to speak to them. We know that many people in hospital rate time to talk and discuss their situation with staff very highly. Our observation is that the named nurse system is not working adequately. Nursing staff are often torn between competing priorities. It can be very difficult for them to set aside time for one to one contact with the people they are there to help. Nurses need more time to talk and build relationships with those seeking to recover. The national review of the role of mental health nurses in Scotland should take this finding into account.

Table 1

Ethnicity and access to information

Hospital	Ward	A.	B.	C.	D.
Newcraigs	Maree	1	0	Y	N
Inverclyde	A East	1	1	Y	N
Carseview	Ward 2	0	0	Y	Y
Whyteman's Brae	Rothes	0	0	Y	N/A
Sunnyside	Ward 8	0	0	Y	N
Royal Cornhill	Drum	0	0	Y	Y
Murray Royal	Moredun B	2	1	Y	Y
Ailsa	Kyle	1	1	Y	Y
Gartnavel	McNair	3	2	Y	N
Stobhill	Struan	0	0	Y	Y
Lochgilphead	Succoth	1	0	Y	Y
Parkhead	Ward 4	1	0	Y	Y
Crichton	Nithsdale	0	0	Y	Y
Stirling Royal	Ward 30	0	0	Y	N
NHS Borders	Huntlyburn	1	0	Y	N
Rosslynlee	Acute Admissions	2	1	Y	Y
Monklands	Ward 24	0	0	Y	N
Royal Edinburgh	Ward 2	0	0	Y	N
Royal Edinburgh	Ward 4	0	2	Y	N
N = 19		**13**	**8**	**All Yes**	**9 No**

Key
A. Ethnic Minority
B. English not 1st language
C. Known access to interpreter
D. Info in language

"Things to do"

We asked the people we met what they had done the day before, what they had done on the day of the visit and what they would be doing the next day. These questions highlighted that in some services there are good arrangements for activities that allow flexibility to meet individual needs. However, the answers also highlighted a poverty of life in the wards where people can spend long periods of aimless time with little contact with staff. Quite a few patients we spoke to referred to anxiety about attending case reviews and the stress of meeting a number of staff in a large group. Staff must be careful not to underestimate the challenge this can be for someone in hospital and make sure that alternative arrangements are available.

Treatment should be a partnership between the person seeking recovery and those who offer help and treatment

Low expectations and higher standards

We think that many people, staff, patients and relatives, will accept standards in mental health services that fall far below what they would expect and demand in other health or residential care settings. In Ward 8 of Sunnyside Hospital there had been no curtains in the dormitories for many months, in Inverclyde Royal for two years there had been a leak in a room often used for interviewing relatives. The drips were being collected in a bin. Complaints were made about the length of time it can take for repairs to be carried out after they have been reported. These are two examples we found during the unannounced visit but we do know of other examples around the country where substandard environments have been tolerated for far too long. Good, clean and comfortable surroundings must be achieved, despite limitations of design.

Our visitors were impressed by the acute ward in Newcraigs hospital with its 24 en-suite rooms and ample communal space. The ward is light, spacious, attractive and appeared well maintained and, apart from some problems with controlling cigarette smoke, was a very pleasant environment to be in.

Patients, clients or customers?

People in hospital are all of these things. Being a patient should no longer mean being the passive recipient of what is thought best for you by doctors and nurses. Treatment should be a partnership between the person seeking recovery and those who offer help and treatment. We did hear many positive comments about the care received from those we spoke to around the country but we also heard angry comments about the facilities people were expected to live in. We know that some of those facilities have remained substandard for many years. In a world of competing health priorities we believe that the condition of the majority of our acute mental health in-patient facilities is visual proof of chronic under investment in the service, which may reflect an undervaluing of those using the service.

"Graffiti on the dormitory wall upset me. When I was unwell I thought it was a message for me".
Patient

"It is a medical type ward designed for obstetrics with vinyl floors and painted walls giving a very cold clinical appearance…if it were still an obstetric ward it would be considered run down and rather scruffy".
Commission visitor

"Very enthusiastic staff with a focus on individual rights. Good audit of activity. Poor conditions mitigated by efforts of staff".
Commission visitor

"One nurse in office – all others with patients. Good relationships between staff and patients. Ward is shabby and institutional. One patient described it as "filthy". Smell of cigarette smoke throughout ward. Very bleak location facing railway tracks".
Commission visitor

When we are in hospital for help and treatment we are in a complex relationship with that service. However, one role is clear, that of customer. We believe that in terms of environment and quality of life the majority of the customers of acute mental health services are not getting a good deal and deserve better.

Consumer feedback

Our unannounced visit incorporated a survey of the views of the people using the services we visited. We think that services themselves should survey the views of their customers more frequently. That information should be fed back to service users and be used as one of the measures of how well that service is performing. It should be used to highlight what is good and what is bad and requires action.

"It's a wonder people stay!"
Commission visitor

Table 2

Locking the doors

Hospital	Ward	A.	B.	C.
Newcraigs	Maree	N	N	N
Inverclyde	A East	N (slow)S	N	Y
Carseview	Ward 2	N	N	Y
Whyteman's Brae	Rothes	N	N	N
Sunnyside	Ward 8	Y	Y	Y
Royal Cornhill	Drum	Y	N	Y
Murray Royal	Moredun B	Y	N	Y
Ailsa	Kyle	N (slow)S	N	N
Gartnavel	McNair	N	N	Y
Stobhill	Struan	N	N	N
Lochgilphead	Succoth	N	N	Y
Parkhead	Ward 4	N	N	N
Crichton	Nithsdale	Y	N	Y
Stirling Royal	Ward 30	N	N	N
NHS Borders	Huntlyburn	N	N	Y
Rosslynlee	Acute Admissions	N	N	Y
Monklands	Ward 24	N	N	Y
Royal Edinburgh	Ward 2	N	N	N
Royal Edinburgh	Ward 4	N	N	N
N = 19		**4Y+2 S**	**Y 1**	**Y 10**

Key
A. Locked
B. Locked permanently
C. Policy available

Acute admission wards should not have locked doors. In any acute admission wards it is likely that some patients will be on raised levels of observation and supervision because their mental state is associated with a degree of risk. There may be restrictions placed on the movements of these patients to ensure that he or she remains in a safe environment. However, these restrictions should not unduly interfere with the freedom of movement of other patients in the wards. There may be situations where it is reasonable to temporarily lock the door of an admission ward because of some clinical emergency but that should only be for the shortest time possible until that situation is resolved.

"It's an unwritten rule that patients are not allowed out for the first 72 hours"
Member of staff

We found that four the 19 wards we visited were locked, one permanently. The three that were temporarily locked had been for some time and not simply to deal with a clinical emergency (see table 2). We do not believe this is acceptable and think that the services involved should review the decision-making process for locking doors in their wards. All services should have a policy and procedure for authorising the locking of ward doors to ensure that any restriction on the movement of people in hospital should be for the shortest period of time possible.

We noted that two of the wards we visited had a "slow door" operating system that delays the opening of a door for a few seconds. These systems seemed to be popular with the patients and staff that we spoke to.

Ward 8 of Sunnyside Hospital is permanently locked. We were told that this was because four of the eight beds of the ward are designated for intensive psychiatric care. Intensive psychiatric care wards are usually locked permanently.

We believe that the inevitable restriction this places on the patients who are not receiving "intensive" care is unacceptable.
The patients we spoke to did feel that their movements were, at times, restricted unnecessarily.

We recognise the security problems that some acute admission wards have. There is a balance between restricting individual freedom and protecting people in hospital. Sometimes unauthorised visitors bring drugs and alcohol into wards putting people at risk. However, preventing unauthorised people coming into wards should not place unnecessary restrictions on patients in the wards. Where there are local difficulties with security, services should consider the use of slow door systems and one-way locking to help maintain a safe environment.

Advocacy

In every ward we visited we were pleased to find that all of the services had access to independent advocacy, with written information available, although there were some references to delays. Of some concern was that of the patients we interviewed, only a little over a quarter said that they had received any written information about advocacy and what it is for (see table 3). Services should review their written information for patients to ensure that information about advocacy is always given to patients. Advocacy services should also ensure that their written information is easily available on wards.

Table 3

Advocacy and advance statements

Hospital	Ward	A.	B.	C.
Newcraigs	Maree	Y	Y	N
Inverclyde	A East	Y	Y	N
Carseview	Ward 2	Y	Y	Y
Whyteman's Brae	Rothes	Y	Y	N
Sunnyside	Ward 8	Y	Y	N
Royal Cornhill	Drum	Y	Y	N
Murray Royal	Moredun B	Y	Y	Y
Ailsa	Kyle	Y	Y	N
Gartnavel	McNair	Y	Y	N
Stobhill	Struan	Y	Y	N
Lochgilphead	Succoth	Y	Y	N
Parkhead	Ward 4	Y	Y	Y
Crichton	Nithsdale	Y	Y	N
Stirling Royal	Ward 30	Y	Y	Y
NHS Borders	Huntlyburn	Y	Y	Y
Rosslynlee	Acute Admissions	Y	Y	N
Monklands	Ward 24	Y	Y	N
Royal Edinburgh	Ward 2	Y	N	N
Royal Edinburgh	Ward 4	Y	Y	N
N = 19		**All Yes**	**All Yes**	**14 No**

Key

A. Advocacy available

B. Written information on advocacy services

C. Advance statement guidance

Advance statements

Taking account of the past and present wishes of someone who is receiving treatment for a mental illness is one of the principles of the new mental health act which comes into force in October 2005. Advance statements are an important representation of that principle and were introduced in October 2004. We were particularly interested to see how much information about advance statements was available at present. While it was relatively early days in the implementation of this section of the new Act, we were disappointed at how few services had any information available. Five of the wards visited did have guides to advance statements available, but 14 had no information at all (see table 3). People can draw up advance statements now and services must make sure that guidance and information is currently available to patients and to staff. We think that advocacy services also have a role to play in ensuring that services have appropriate information available to patients.

Access to telephones

Admission to hospital can be isolating. Staying in touch with relatives and friends is very important in times of crisis. Often when someone is admitted to hospital there are personal matters that need to be dealt with urgently. This can mean that the telephone is a vital means of communication. We often hear complaints from patients about the lack of private access to telephones. We are also very aware of how difficult this can be when we are speaking to people in hospital who have telephoned us for information or advice. Trying to discuss personal matters in a public place where others can overhear you is inappropriate and does not help in stressful circumstances. While we know that staff do try to help provide private places to telephone, generally the facilities for private calls are not satisfactory. Around half of the wards visited do not have access to telephones with adequate levels of privacy (see table 4).

Three of the wards visited do not allow the use of mobile phones within the wards. The reasons given are because of the nuisance mobile phones can be to others and for reasons of security, particularly where there are problems with illegal substances on a ward. While services have to make decisions about local access to mobile phones we are wary about "blanket" decisions that prevent access for all. It may be that patients in a ward are happy to forgo the use of mobile phones in the interests of living communally and, realistically, there are situations where an individual's access to a phone should be restricted because of some risk (the new Mental Health Act sets out regulations on access to phones for detained patients). However, any restriction should not prevent an individual patient keeping in contact with family and friends.

Table 4

Access to telephones

Hospital	Ward	A.	B.
Newcraigs	Maree	Y	Y
Inverclyde	A East	Y	D
Carseview	Ward 2	Y	Y
Whyteman's Brae	Rothes	Y	Y
Sunnyside	Ward 8	N	Y
Royal Cornhill	Drum	Y	Y
Murray Royal	Moredun B	Y	Y
Ailsa	Kyle	N	Y
Gartnavel	McNair	N	N
Stobhill	Struan	Y	Y
Lochgilphead	Succoth	Y	Y
Parkhead	Ward 4	N	N
Crichton	Nithsdale	N	Y
Stirling Royal	Ward 30	Y	Y
NHS Borders	Huntlyburn	N	N
Rosslynlee	Acute Admissions	N	Y
Monklands	Ward 24	Y	Y
Royal Edinburgh	Ward 2	N	Y
Royal Edinburgh	Ward 4	N	Y
N = 19		**9 No**	**3 No**

Key
A. Private telephone access
B. Use of mobiles

Any restriction should not prevent an individual patient keeping in contact with family and friends

We met with one patient who was using her mobile phone to text her daughter before she went to school in the morning as a way of keeping in touch and showing she was thinking of her. Because of a "blanket" rule in the ward, she was denied access to her mobile phone and could no longer send the messages. Clearly this was unacceptable and special arrangements should have been made for her.

Availability of psychological services

We asked staff about access to allied health professionals. A very clear message came across that there are insufficient resources to provide specialist psychology assessment and intervention in acute services throughout the country.

Key Messages

We ask that services take into account these key messages and consider how they apply to their services.

- People receiving treatment in hospital were largely positive about the way staff treated them, valued time spent with staff, but wanted more.
- Too many women felt unsafe.
- Many units were shabby, poorly maintained, sparsely furnished and unpleasant. Private space was often very limited.
- In most wards, the named nurse or keyworker system was not working. Nurses told us that they did not have enough time to talk with service users.
- Though written information was available for service-users, it often did not reach them.
- Information for patients about Advance Statements was the exception, rather than the rule.
- In many wards, there was not enough privacy for service-users to make personal telephone calls.
- There were insufficient psychological services available.
- Staff knew how to access interpreting services. However, there was a dearth of written information for people whose first language was not English.
- Some wards were locked for prolonged periods.
- Some acute admission wards provided appropriate activities for people in hospital but many did not.

What we think needs to be done

While there are positive messages from our visits, we think much needs to be done to improve acute care in Scotland. In a world of competing health priorities we believe that the condition of the majority of our acute mental health in-patient facilities is visual proof of chronic under investment. We ask that the Scottish Executive makes sure that its prioritisation of mental health and well-being takes into account people who are ill and in need of acute care. At an operational level we believe that immediate steps can be taken to improve the quality of life for people in acute care. Services need to take a fresh and critical look at their acute admission wards.

Services should survey consumer views more often and use the information to prioritise areas for improvement. Environments should be improved and expectations of what is acceptable should be raised. Good quality pleasant environments can be achieved. People in mental health services deserve to be treated with respect.

Currently there is debate in Scotland about the need for a change in the culture in acute mental health services. We think that the time is right for a review of acute services, particularly given the Scottish Executive's programme for improving mental health in Scotland and the advent of the new Mental Health (Care and Treatment) (Scotland) Act 2003.

We are sending this report to the Scottish Executive, to health boards, local authorities, to advocacy and user organisations and will ask that alongside the many developments and innovations in mental health care in Scotland special attention is paid to acute care in mental health services.

Appendix 1

Bed occupancy at time of visit

Hospital	Ward	A.	B.	C.	D.
Newcraigs	Maree	24	22	13	9
Inverclyde	A East	19	13	10	3
Carseview	Ward 2	24	21	9	12
Whyteman's Brae	Rothes	29	24	12	12
Sunnyside	Ward 8	10	10	5	5
Royal Cornhill	Drum	28	24	12	12
Murray Royal	Moredun B	22	21	21	0
Ailsa	Kyle	29	30	14	16
Gartnavel	McNair	24	25	15	10
Stobhill	Struan	20	20	12	8
Lochgilphead	Succoth	26	22	6	16
Parkhead	Ward 4	24	24	15	9
Crichton	Nithsdale	22	22	12	10
Stirling Royal	Ward 30	24	21	8	13
NHS Borders	Huntlyburn	30	24	11	13
Rosslynlee	Acute Admissions	25	15	10	5
Monklands	Ward 24	25	20	13	7
Royal Edinburgh	Ward 2	25	25	12	13
Royal Edinburgh	Ward 4	25	37	19	18
N = 19		455	420	229	191

Key:
A. Beds
B. Occupied
C. Male
D. Female

How to contact us

How to contact us

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