Mental Welfare Commission for Scotland

Report on announced visit to:
Tippethill House, Rosebery Wing, Armadale, West Lothian EH48 3BQ

Date of visit: 1 August 2024

Where we visited

Rosebery Wing in Tippethill House provides care and treatment for females, over the age of 65 years, with a diagnosis of dementia and who have complex care needs. The ward capacity has significantly reduced from 22 to eight single rooms since our last visit in June 2022 and the ward was at capacity on the day of this visit.

Our last visit to the service was announced and we made recommendations about the level of consultant psychiatry and occupational therapy (OT) input to the ward. We also made recommendations in relation to information being recorded in the electronic patient records, highlighting that medical staff should be recording comprehensive entries and that nursing care plans should provide summative evaluations with a further recommendation about ensuring all disciplines provided input to the multidisciplinary team (MDT) meetings.

The response we received from the service was that the level of consultant psychiatry input was considered appropriate due to the ward operating at a reduced level of no more than 10 individuals at that time. We were also advised that an additional OT resource to all hospital based complex clinical care (HBCCC) wards was being provided on a temporary basis to allow the level of input required be established and for a model for OT and activities provision to be developed.

Physical health care was now covered by advanced nurse practitioners (ANPs) supported by consultants located in St John's Hospital, Livingston with entries being routinely recorded in TRAKCare, the electronic patient record system. Previously this had been provided by general practitioners (GPs) however, the contract was not renewed.

Changes in how nursing staff recorded evaluations had been made and training was provided by the senior charge nurse (SCN) and charge nurse (CN) to improve the content of entries and overall quality of documentation. Additionally, a canned text MDT meeting template had been introduced so that relevant disciplines could provide a summary to ensure wider MDT involvement when they were unable to attend the MDT meetings.

During this visit, we wanted to meet with people receiving care and treatment and follow up on the previous recommendations.

Who we met with

Due to the progression of illness, we were unable to have in depth conversations with individuals however, we were able to observe them in the ward environment, interacting with staff and ourselves throughout the day. We reviewed the care records of six people. We also met with one relative during the visit and spoke to another in a phone call prior to this.

We had an online meeting with the SCN prior to the visit and met them again along with the general manager (GM), CN, nursing staff and clinical nurse manager (CNM) from adult mental health services, who was covering until this new member of staff had taken up the appointment

Commission visitors

Denise McLellan, nursing officer

Gordon McNelis, nursing officer

What people told us and what we found

Although we were unable to obtain detailed views from the individuals receiving care and treatment, we witnessed staff engage with and understand those who were having difficulty expressing themselves to communicate their needs.

We saw warm interactions that showed a genuine consideration and kindness. An example that we observed was after an interaction between one health care support worker (HCSW) and an individual; we saw the individual walking away smiling and relaxed, and heard them comment “she’s a good girl” about the HCSW

In a telephone call with one individual’s relative, they gave us very positive feedback about the care their loved one was receiving in Rosebery Ward. They told us that their relative was treated with respect and in their view, enjoyed a good relationship with staff. They added that they were always notified promptly of any incidents, such as minor falls and that nursing staff were “very good at keeping me informed”. They told us that they have had face to face meetings with the responsible medical officer (RMO) and mental health officer (MHO) and understood information they had been given regarding mental health legislation.

They advised us that “if she has to be anywhere other than home, this is the best place for her” and “I don’t think she could get a higher standard of care elsewhere” They said this view was shared by other relatives and friends who visited regularly adding “everyone says they are impressed by what they see”. They described the environment as “bright and well decorated with nice pictures around” and told us that the café area in the ward was a good resource for visitors. They also felt confident that personal belongings were looked after. The only issue they wished to raise was difficulty accessing podiatry.

During our visit we met another relative who highly praised the staff and the level of care provided, noting the consistency of care. They spoke about challenges that the illness brought for their relative and how difficult this could be to manage. In their view, staff had “saved her life and she’s thrived” and that the care was “great”.

Their only concern related to the uncertainty around proposals to relocate the ward to a different facility approximately 10 miles away. They reported an inconsistency in information provided by the health board to what was being reported in the local press.

Care, treatment, support, and participation

We noted from feedback from relatives that they felt supported and kept informed. Relatives were not invited to MDT meetings, however we were told that they were encouraged to attend HBCCC reviews and discharge planning meetings when a care home had been identified. Where unable to attend, staff encouraged participation by facilitating phone call attendance using the speaker facility.

Care records

Information was held between TRAKCare and paper files. We were told the reason for this was that given its remoteness from the main hospital in Livingston, it was felt that relying solely on information technology (IT) systems would be too risky. Managing information this way provided some reassurance to the team that relevant information would be accessible in the event of IT problems. We were able to access information with relative ease.

We found that family meetings were documented on TRAK and included details of the discussion about current and proposed future care provision. Family involvement was evident from the level of information contained in the 'Getting to know me' booklet which captured personal information, including preferences and dislikes and what mattered to the person. This valuable information was then utilised in the care plans to suggest helpful interventions that could minimise the level of stress and distress experienced. The continuation notes also recorded family/carer presence on the ward.

There was a clear focus on physical healthcare, with evidence of recent dental treatment, treatment for infections and detailed past medical histories. Physical health assessment tools were completed and available on TRAK. We saw evidence of family involvement in relation to an individual's dietary requirements and evidence of risk information being shared with families, such as risk of falls and how this could be minimised. Do not attempt cardiopulmonary resuscitation (DNACPR) documentation was completed accurately and in conjunction with proxy decision makers or relatives.

There were individualised, person-centred care plans covering mental and physical health, including ones for stress and distress guided by the Newcastle Model. Behaviours that challenge can be common in dementia and the Newcastle Model is a clinical approach that aims to understand and manage these. It uses a person-centred approach to identify and fulfil the unmet needs of the person. We found these care plans to be detailed, containing information about triggers, what the barriers to communication could be and interventions to help alleviate this; this made them easy to understand and it was clear there had been collaboration with families from information provided about the best way to communicate and strategies to help people settle before use of medication.

Although these care plans were comprehensive and regularly reviewed, it was difficult to find details of how the care set out in them was managed on a day-to-day basis. One-to-one contacts between individuals and staff were of a mixed quality, with some being detailed and others having limited content. We discussed this with managers who advised that care plan auditing continues monthly, and these specific areas can be given more focus.

Recommendation 1:
Managers should ensure that the level of information contained in one-to-one contact records and continuation notes is consistent and reviewed as part of the monthly audit process.

Multidisciplinary team (MDT)
We had previously been advised about a shortage in older adult consultant psychiatrists in the health board and that following recent retirement, a locum doctor had been providing cover, although they had left the previous month. We were told that recruitment was ongoing to fill this vacancy.

Unfortunately, we were unable to find evidence of psychiatry reviews or MDT discussion recorded during the last four-week period and raised this as a concern with senior managers. We were told that in the short term, cover would be provided by the three consultants from Ward 3 at St John's Hospital and that a crisis meeting was planned for the following week to look at the longer-term arrangement.

In the interim period, nursing staff had reactively contacted the psychiatry team at Ward 3 for input as matters arose.

Recommendation 2:
Managers should review the level of consultant psychiatrist input to the ward to ensure there is adequate medical oversight and that all individuals are reviewed on a regular basis.

OT provision consisted of one fortnightly session with a full-time activities' co-ordinator now in post. There was pharmacy input to the ward for medication reviews and they could be contacted by phone or email. There was evidence of social work involvement at previous meetings from social workers based at St John's Hospital.

We were told that there was currently no psychology provision into the unit although referrals could be made to the West Lothian psychological approach team 'Welpat' for support with distressed behaviour.

Referrals to other disciplines, such as speech and language therapy and dietetics could be made as required. The MDT meeting template was well structured and included a record of attendance.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was available and in order.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Two of the individuals subject to the Mental Health Act were receiving treatment in the first two-month period of detention, therefore did not yet require a consent to treatment certificate (T2) or certificate authorising treatment (T3). The SCN verified that a second opinion visit had been requested to ensure that medication would be legally authorised in the necessary timeframe for one of these individuals.

We noted that the certificate authorising treatment (T3) under the Mental Health Act for another individual did not authorise an 'if required' benzodiazepine that had been prescribed. We highlighted this to the SCN who agreed to escalate this to medical staff.

For those subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we found copies of a welfare guardianship order (WGO) and power of attorney (PoA) certificates in the paper files. We also saw information relating to a WGO application in the electronic records. Additionally, we found proformas relating to consent for things such as photography and a letter to a PoA with information about the covid and influenza vaccines with consent forms attached.

Where 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 Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found certificates in place with the corresponding treatment plan and that there had been discussion with the relatives.

On one form we noticed that a date of examination had been recorded erroneously and on another the date of discussion with relatives had been omitted. We were told that these forms had been completed in other areas prior to admission to Rosebery Ward. The SCN agreed to highlight these discrepancies to medical staff to have this rectified.

Recommendation 3:
Managers should implement an audit process to ensure that information contained in s47 certificates is accurate and complete.

For patients who had covert medication in place, we saw multidisciplinary agreement and a date for this to be reviewed as well as a record of consultation with families. There was one which was due to be reviewed in June 2024 however, we were unable to find any record of this.

Recommendation 4:
Managers should ensure that there is an audit process in place to ensure that any medication given covertly is reviewed regularly.

The Commission has produced good practice guidance on the use of covert medication.[1]

Rights and restrictions

The ward operates a locked door policy commensurate with the level of risk. The policy was displayed on an information board adjacent to the ward entrance along with other pertinent information about protected mealtimes and visiting arrangements.

No individuals were subject to continuous intervention for risks relating to their illness, but we were made aware of one lady who had increased support due to her risk of falls; this had been risk assessed and documented in her care plan.

We were told that EARS independent advocacy had been accessed previously. However, no one was currently using this service, but referrals could be made when required.

Activity and occupation

Since our last visit the ward had benefitted from the addition of a full-time activities' co-ordinator. Generally, they worked Monday to Friday, with nursing staff delivering activities at weekends. However, there was flexibility to adapt the working pattern where desired.

We were pleased to see that the Pool activity level (PAL) instrument had been used as the framework for providing activity-based care. This tool is recommended for daily living skills training and activity planning in the National Institute for Clinical Excellence (NICE) guidelines for people with cognitive impairment, including dementia.

The daily activity programme provided opportunity for meaningful activity and the documentation we viewed included one-to-one contact records with examples of detailed descriptions about how individuals presented. We identified regular reviews and completed activities checklists.

We saw personal history profiles that contained detailed background information, obtained from relatives. This information was held in paper format, and we considered that it might have been helpful to have this stored alongside other records on TRAK for wider accessibility.

[1] *Covert medication good practice guide*: https://www.mwcscot.org.uk/node/492

The physical environment

The layout of the ward consisted of individual bedrooms with an en-suite toilet and sink facilities and communal access to one shower and two bathrooms. We were told this was considered sufficient and worked well in accordance with respecting people's personal care preferences, allowing for use at differing times.

The rooms were clean, bright and airy and we noted that they had been personalised with photos. There were also some considerate touches that had been introduced during the pandemic, such as the knitted love hearts inserted into the information boxes on the front of room doors.

The communal areas were welcoming and homely with sufficient seating areas arranged around the ward for individuals to rest or enjoy the company of others. The furniture was of a good standard, clean and in a good state of repair.

The dining room was spacious with large windows allowing individuals to enjoy the view of the gardens that were visible from this room. Use of large round tables gave the impression of a less clinical setting making it more appealing and aesthetically pleasing.

We had also heard feedback from relatives about the café area being a relaxing place to meet family and celebrate events, such as birthdays. We saw a variety of interactive fidget board equipment for use, and there was a well-designed mural that had been painted by art students at the entrance to the gardens.

The garden area was spacious and well maintained, affording a good level of privacy to individuals and their visitors

Any other comments

We were told about a possible merge and change of location to the Craigshill facility around 10 miles away, but this was at a very early stage in planning. We remain interested to learn of any new developments regarding these proposals.

Summary of recommendations

Recommendation 1:
Managers should ensure that the level of information contained within one-to-one contact records and continuation notes is consistent and reviewed as part of the monthly audit process.

Recommendation 2:
Managers should review the level of consultant psychiatrist input to the ward to ensure there is adequate medical oversight and that all individuals are reviewed on a regular basis.

Recommendation 3:
Managers should implement an audit process to ensure that information contained in s47 certificates is accurate and complete.

Recommendation 4:
Managers should ensure that there is an audit process in place to ensure that any medication given covertly is reviewed regularly.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

Claire Lamza
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 Commission 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 an individual's care, treatment, and support are 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.

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