Mental Welfare Commission for Scotland

Report on announced visit to:
Midlothian Community Hospital, Penny Lane and Rose Lane Wards, 70 Eskbank Road, Bonnyrigg, EH22 3ND

Date of visit: 19 November 2024

Where we visited

Penny Lane and Rose Lane wards provide inpatient care for people over 65 who require admission for mental health care in Midlothian. Based in Midlothian Community Hospital, the adjoining wards have a total of 20 beds and occupy the footprint of the former Rossbank Ward.

Historically, Rossbank was a 24-bedded ward, caring for older adults with functional mental illness and for those with dementia who required inpatient assessment. Next to it, Glenlee Ward provided 20 beds for older adults with a diagnosis of dementia and complex needs who required hospital-based complex clinical care (HBCCC). A substantial number of people admitted to these wards were from East Lothian and were receiving care in Midlothian due to a lack of facilities in their local area. When plans were put in place for a new ward to open in East Lothian in 2020, plans were progressed in Midlothian to close Glenlee Ward and re-develop Rossbank Ward, dividing it into two smaller units. These were to provide care for people with the same needs that both wards previously offered.

The new wards opened early in 2020, just at the start of the Covid-19 pandemic. Penny Lane is a 12-bedded, mixed-sex ward providing care for people with a diagnosis of dementia who require either hospital assessment, or longer term HBCCC care. Rose Lane, an adjoining annexe, is an eight-bedded mixed-sex ward caring for people with functional mental illness.

The Commission last visited in July 2022 on an announced visit and made recommendations on optimising communication, feedback and participation with carers, prioritising psychology provision and the completion of medical certificates to authorise treatment for individuals who lacked capacity to consent to their treatment.

The response we received from the service set out an action plan to address these issues.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear feedback from individuals, carers and staff about their experiences.

On the day of our visit, there were 20 people in the wards, with no vacant beds.

Who we met with

We met with and reviewed the care of eight people, six of whom we met with in person and eight of whom we reviewed the care notes of. We also met with four carers on the day and spoke with another relative prior to the visit.

We met with the service manager, the senior charge nurses and other ward staff. Following the visit, we liaised with the advocacy service to hear about their experience of providing input to the wards.

In addition, we met with the lead nurse for quality improvement and standards of care in the hospital.

Commission visitors

Juliet Brock, medical officer

Lesley Paterson, senior manager (practitioners)

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support, and participation

The feedback we received on the day from individuals and from family members was overwhelmingly positive. Some quotes from carers included “It’s a super unit!”, “They are lovely, every single member of staff”.

Families told us that the care provided was “excellent” and they “couldn’t fault” the care of their loved ones. They spoke about there being a good staff presence on the ward and that staff went “above and beyond” to provide care. We saw evidence of this on the visit, both in the interactions observed between staff and individuals and in examples of kind and thoughtful care we heard throughout the day.

One relative commented that rather than relying on medication, the staff took a “human approach” to care. They spoke of how their parent was “completely transformed” since admission and attributed this improvement to the “experienced and skilled” staff team providing care.

We also heard positive comments about the level of physical as well as mental health care provided.

Almost all carers said that communication from the staff team was good, that they were kept updated and felt very involved in their relative’s care.

One person had a slightly less positive experience about communication and told us they hadn’t felt as involved in discussions about their relative’s discharge plan and ongoing care as they would have liked. Otherwise, their experience had been very positive, and they were highly complimentary about the team and the care their loved one had received.

Another carer, who spoke with us prior to the visit, described a positive experience of the discharge planning process. They told us they were invited to every meeting and had regular contact with the community team prior to discharge, which helped them to feel confident and supported when their spouse returned home.

Those individuals who were able to tell us themselves about their experience on the ward spoke of staff being kind, approachable and caring. People felt they were treated with dignity and respect, and we heard no negative feedback or suggestions for improvement.

Multidisciplinary team (MDT)
The multidisciplinary team consisted of nursing staff, a consultant psychiatrist, supported by other medical staff and input from occupational therapy (OT) and activity co-ordinators.

Input from physiotherapy, speech and language therapy and dietetics could be arranged by referral on an individual basis when required.

On both wards there were weekly MDT meetings which a specialist mental health clinical pharmacist continued to attend. Professionals from community services were also able to join where appropriate. Ward staff also continued to have a 'rapid run-down' meeting with the medical team every Friday.

We heard about the absence of any clinical psychology input on our last visit and made a recommendation for managers to prioritise the provision of psychology. We heard on this visit that this had not been possible. The provision of the service was resourced centrally by NHS Lothian, and we heard that psychology was being withdrawn across the health board due to an absence of resource. We are aware from recent contact with the professional lead for NHS Lothian older people's psychology service (LOPPS) that lack of provision is a significant concern for a number of services, but this is an issue which is continuing to be addressed. Managers at Midlothian advised that they continued to make a case for this resource.

At the last visit there had been a reduction in OT support, with OT staff no longer being able to join weekly MDT meetings due to reduction in capacity. On this visit we heard that there continued to be an OT and OT assistant working in the service, but that a further OT post remained vacant, following several unsuccessful attempts to recruit. We were told that managers were reviewing the banding of the post (from band 5 to band 6) prior to re-advertising it.

When we last visited, both wards were experiencing significant staffing challenges, with shortages in permanent staff meaning that agency and bank staff were often required to support shifts. We were pleased to learn on this visit that staffing levels were much improved. This followed local events promoting the service and successful recruitment. Penny Lane had a full complement of staff and Rose Lane had only a few vacancies for registered nurses.

The two senior charge nurses on the wards were new in post, having only recently joined the service. There was a second assistant nurse practitioner providing support to the service, with a focus on physical health and wellbeing and funding had also been secured for a second advanced nurse practitioner (ANP), who would be specialist mental health nurse.

Managers advised that training had also been a major focus over the past year, following the appointment of an education co-ordinator for the hospital, a new permanent post. This had reportedly made a significant difference, enabling staff to update their training, including over 80% completing training in dementia care. We heard the education facilitator was also establishing connections with further education to expanded training resources and it was hoped that this would widen training opportunities for staff in the future.

Care records

Care records continued to be mainly held on the electronic record system TRAKCare.

In the records we examined, we found that entries in the daily care records were variable in quality. We saw some excellent examples of detailed, individualised entries, with a positive, strengths-based approach and strong mental health focus. In others there was sometimes a tendency to focus on physical aspects of care, to the detriment of recording the person's mental state and participation in activities. The use of 'canned-text' headings was variable. We wondered if broader use of this could help prompt the recording of wider aspects of care and experience.

We did not see clear evidence of nursing one-to-one meetings in the care records we reviewed. It appeared that these were likely taking place but were not clearly identified as such in the care records. We suggested to senior staff that this could be easily rectified in the labelling of entries in the care records.

We noted that staff were spending a lot of time on physical health checks during the day, known as 'care rounding'. Whilst this was appropriate for some individuals who had complex physical health needs, for others it appeared unnecessary and took the focus away from their mental health care. This is an issue we have noted in other older adult mental health services in NHS Lothian. We discussed this matter with the manager and lead nurse for quality improvement on the visit. Although it was acknowledged that this physical health focus could sometimes be disproportionate for individuals, it was explained this was required as part of LACAS (Lothian accreditation and care standards) and was therefore an essential part of everyday care provided by all staff across the hospital.

We saw detailed entries from other members of the MDT, including medical staff, OT, physiotherapy, dietetics and social work. We also saw good evidence of physical health reviews in the ANP records.

MDT meetings records followed a standardised format and were detailed and well written in the files we reviewed. There was clear evidence of discussions with individuals and their families and of discharge planning.

We did note in some individual cases that there was a lack of focus on risk assessment in the recorded MDT discussion, where we would have expected this in

the context of the individual's history. We also found that the risk assessments themselves lacked consistency, and in some cases did not appear to have been reviewed or updated since the person was admitted to hospital from the community. The lack of a robust, up to date risk assessment and clear risk management plan was a concern, particularly in cases where, for example, there was a known risk of suicide.

Recommendation 1:
Managers should ensure that each individual has a full mental health risk assessment that identifies all known risk factors, is regularly reviewed and accompanied by a robust risk management plan. Risk assessments should be regularly audited to ensure these standards are met.

Care plans
Nursing care plans were again of mixed quality, something we also found on our last visit. We found some good examples of person-centred care planning, but this was not consistent in the files we reviewed. In Penny Lane, we found some very detailed stress and distress care plans, which were highly individualised and person-centred. In Rose Lane we found that some care plans for individuals with functional illness lacked clear treatment goals and details of interventions.

We were told that all care plans were audited using LACAS. However, on discussion it was evident that this audit system focussed on the standard physical health care plans, which were required by hospital managers to be completed for everybody, but which were not primarily mental health focussed. We discussed with senior managers on the day and how audit might be implemented with a specific mental health focus, more tailored to the individuals on the wards.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Recommendation 2:
Managers should ensure that all individuals in the wards have an individualised and person-centred care plan in response to their identified mental health needs, which identifies clear interventions and care goals. The quality and review of these should be regularly audited.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Use of mental health and incapacity legislation

In the files we viewed, all documentation relating to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) and the Adults with Incapacity (Scotland)Act, 2000 (the AWI Act) was in place.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed, in all but one instance; one prescribed medication was not listed on the person's T3 certificate. We alerted staff to this on the day to ask the medical team to review the error. We advised that audits are carried out to regularly check prescribing and that all treatment is appropriately authorised by T2/T3 forms.

The service had not yet moved to electronic prescribing and continued to use paper prescription kardex. Kardexes stated clearly whether each individual was subject to the Mental Health Act and whether a T2 or T3 was in place, with copies of these filed alongside individual kardex.

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 that each individual kardex also stated whether the person was receiving treatment under the AWI Act had a section 47 certificate in place. The expiry date of this was noted on each kardex. We found section 47 certificates in place where required, accompanied by individual treatment plans.

For individuals who had covert medication in place, appropriate documentation was present, with covert medication pathways completed and regularly reviewed.

The Commission has produced good practice guidance on the use of covert medication.[2]

Rights and restrictions

The wards operated a locked door, commensurate with the level of risk identified with the patient group.

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

Individuals who spoke with us told us that they felt involved in decisions about their care and treatment and we found evidence of good participation with individuals and their relatives.

Information leaflets continued to be provided for individuals and their families, which included details about advocacy support.

In the case records we viewed we found little reference to advocacy or recording of matters relating to individuals' rights, however, the staff spoke positively about the input to the ward from EARS independent advocacy service and following the visit we contacted the advocacy service for their feedback.

We were pleased to hear from EARS that advocacy was positively supported by the nursing and medical staff on the ward. Most referrals were received from mental health officers (MHOs) for individuals on the ward, but occasionally nursing staff made referrals. We heard there was ongoing advocacy support for a number of individuals on Rose Lane ward and that there had been recent referrals for some individuals on Penny Lane. The advocacy worker told us the service manager was keen that people who had been in hospital for some time also had the opportunity to hear about advocacy.

We heard that in the past individuals had raised concerns with advocacy about the mix of people on the ward, particularly from those who did not have a diagnosis of dementia who had sometimes struggled with being in the same environment as individuals who did, who were quite confused at times. People had also raised issues previously about not getting out for passes, particularly if they were reliant on ward staff to take them out. It was good to hear that these were no longer concerns being raised with advocacy and that there were no issues at the time of our visit.

The Commission has developed *Rights in Mind.*[3] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to hear that both wards continued to have activity co-ordinators in addition to OT support.

Rose Lane offered a broad activity programme, despite being a small unit for eight people. Individuals had personalised activity timetables in their bedroom and there was a timetable in the communal area detailing group activities available that week. We observed evidence of such activities on the day of the visit, with a lively newspaper discussion group in action in the morning. If a person was struggling to engage in groups, they were instead offered one-to-one activities, supported by the

[3] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

staff. We heard feedback from family members, who said they were impressed by the frequency and range of activities available on Rose Lane “there’s plenty on offer, twice or three times a day”.

On Penny Lane we were also pleased to note that activities for individuals with dementia were much improved. When we last visited, staff had expressed concern about people on Penny Lane lacking some stimulation. At that time there had only been a recent appointment to the post of activity co-ordinator, and we heard that they were sometimes “pulled into” doing other tasks on the ward when staffing was short. This no longer appeared to be a concern. There were group activities as well as individual support. Some individuals had ‘playlists for life’, developed by the OTs, and there was also specialist equipment available to help engage people.

We did hear from some individuals and relatives that weekends were quiet. This could be an area of further improvement for the service to consider.

The physical environment

Penny Lane, accessed directly from the hospital corridor, comprised the majority of the footprint of Rossbank Ward. Rose Lane occupied a much smaller footprint at the back of the ward, having previously been divided off as a separate unit. There had been significant positive changes to the environment in the wards since our last visit.

Penny Lane Ward

The main communal area on Penny Lane comprised a large, bright, open plan lounge/dining area, opening onto a private courtyard garden. This communal space had been upgraded since our last visit and was thoughtfully decorated to provide a comfortable and welcoming environment. Additions included new furnishings and sound absorbing picture panels on the walls. Previously we had heard about noise levels on the ward being a challenge and causing distress to many individuals. The panels were therefore a welcome addition and staff told us these had made a significant difference, particularly at mealtimes when the ward was busy.

The additional shared spaces around the ward had also continued to be developed. There was a large activity room which was also now used as a cinema. In addition to a projector and screen, comfortable sofas had been purchased, and we heard that the activity co-ordinators hosted films on a regular basis. In addition to art materials, activity equipment included specialist dementia tools such as a RITA machine (reminiscence interactive therapy and activities), an electronic portable interactive device was in use. A dedicated sensory room on the ward had also been further developed since our last visit (when it was part used for storage). This now provided a calm and relaxing space with multi-sensory equipment. The corridor spaces were awaiting decoration, and we were told that more dementia-friendly signage was being investigated.

There were 12 en-suite bedrooms on the ward, including two anti-ligature rooms, for people deemed to be at high risk. A number of bedroom doors had been upgraded with dementia-friendly decals, giving them the appearance of brightly coloured front doors. This helped individuals identify their own room. We were advised that more were due to be completed. We saw evidence of individuals being able to personalise their rooms with photographs and items of importance to them. In addition to en-suite shower rooms, there was an accessible bathroom for those wishing to have a bath.

Accessed from the main communal area on Penny Lane, the enclosed garden space offered seating, sheltered spaces and areas of interest, such as raised beds. Access to the garden was mainly locked during the day, with individuals requiring supervision to access the space. We were told that this outdoor space continued to be well-used by individuals and their relatives during the summer months.

Rose Lane Ward
When we last visited in 2022, Rose Lane was only accessible through Penny Lane, via security doors at the end of ward. At that time, we heard from some family members that walking through the communal area in Penny Lane to visit a relative in Rose Lane Ward could feel upsetting. The staff also recognised that this situation was far from ideal.

There were plans to create a new entrance for Rose Lane, accessed directly from the grounds of the hospital. Funding was in place and the works were awaited but had been delayed when we last visited. On this visit, managers explained that unfortunately there had been some technical difficulties with the new access, but it was anticipated that this would be resolved in the near future.

The communal spaces in Rose Lane had been transformed since our last visit. The lounge was a large, bright, welcoming space with comfortable furniture and pictures on the walls. A further large room, that in the past had mainly been used for meetings, had been adapted into a multifunctional space for the inpatient group. It was divided up to provide an activity area (where a group activity was taking place around a table), a games area with pool table, a seating area for relaxing and reading and a hairdressing space. Items had been donated to comfortably furnish the room. We were told that the space was well used and enjoyed by those on the ward.

The eight en-suite bedrooms were light, bright and could be personalised. We saw evidence of individual timetables in people's rooms.

Since our last visit, access had been made available to an outdoor space solely for the use of Rose Lane. The enclosed paved garden area was accessed directly from communal space on the ward. Funds had been acquired for wooden furniture and a gazebo and there were plans for engaging the inpatient group with outdoor activities

and gardening during warmer months. We were told that the space was well used by individuals and their relatives.

Any other comments

We received some feedback from carers about negative experiences in the community prior to their relative being admitted to hospital. This was in relation to feeling unsupported by community services, who we heard were very stretched. We gave this feedback to senior managers at the end of the visit.

Both wards were full at the time of our visit and there was a waiting list for admissions. We were aware of recent cases where older adults from Midlothian had been admitted to the Royal Infirmary in Edinburgh (a general hospital) in crisis, had been detained in hospital, but whose transfer to a specialist mental health bed had been delayed due to a lack of available inpatient beds.

We heard that delayed discharges remained a problem on the unit, with three people on Rose Lane and four people on Penny Lane being delayed at the time of our visit due mainly to waits on care home beds. We were advised that this situation was constantly under review by the flow hub and that there was a good relationship with the discharge team in the hospital.

Summary of recommendations

Recommendation 1:
Managers should ensure that each individual has a full mental health risk assessment that identifies all known risk factors, is regularly reviewed and accompanied by a robust risk management plan. Risk assessments should be regularly audited to ensure these standards are met.

Recommendation 2:
Managers should ensure that all individuals in the wards have an individualised and person-centred care plan in response to their identified mental health needs, which identifies clear interventions and care goals. The quality and review of these should be regularly audited.

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.

Contact details

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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk