Mental Welfare Commission for Scotland

Report on an announced visit to:
Stracathro Hospital, Rowan Unit, Susan Carnegie Centre, Brechin, DD9 7QA

Date of visit: 3 December 2024

Where we visited

Rowan Unit is based in the Susan Carnegie Centre and is part of the older people's psychiatry service, situated in the grounds of Stracathro Hospital in Brechin. It is a mixed-sex unit with 12 beds providing admission, assessment, and treatment for older people with functional mental health problems. Admission to the unit is usually through the older peoples' mental health multidisciplinary teams (MDTs) based across Angus.

During our announced visit we wanted to speak with individuals, relatives, and staff. We were keen to find out how the service was implementing the recommendations from the last visit to the service.

On the day of our visit, there were 12 of people in the unit and no vacant beds.

We last visited this service in October 2023 on an unannounced visit and made three recommendations. The recommendations were that managers should review the current MDT documentation and ensure that the record captured the MDT weekly discussion, records actions and outcomes, and the individual views about their care and treatment. A system was required to ensure all treatment certificates were in place and that all prescribed medication was legally authorised, where appropriate. All activities were to be recorded and linked to individual care plans, noting what the benefit was of the activity for the person.

During this visit, we wanted to follow up on the previous recommendations and hear how the actions had progressed. We found the progress had been slow in relation to the effective recording of activities. There was clear evidence that all prescribed medication was prescribed legally. There was also some progress in the recording of MDT meetings in line with mental health services in Tayside. The unit and senior management team were keen to work with the Commission and action any unmet recommendations and any further recommendations from this visit.

Who we met with

On our visit, we met with three individuals who wished to speak with us, and reviewed three sets of case records. We spoke with two relatives via the telephone, with one of the carers we spoke with keen to give the Commission their experience as a carer.

We also spoke with the senior charge nurse, charge nurse, staff nurse, the senior nurse and consultant psychiatrist during our visit.

Commission visitors

Sandra Rae, social work officer

Denise McLellan, nursing officer

What people told us and what we found

We sought feedback from individuals and relatives in relation to their care and treatment and their experience in the unit. This was mostly positive. Individuals described staff as “kind,” “caring,” “second to none” and helpful,” and told us the staff “look after us well.”

The individuals we met with were able to tell us about their involvement in their care and treatment and about their journey to recovery, whilst others told us about their involvement in their discharge planning. We were told from relatives that the communication with families was not as good as they would like it to be, and they did not feel they were kept up to date or as included in the care and treatment of their family member as they could have been.

We were told that individuals saw their consultant psychiatrist regularly, who discussed their care with them, however, a relative informed us that apart from the discharge planning meeting, the conversations with psychiatry had been in the corridor and not planned, which they felt was disappointing.

We heard from individuals that the internet connection was not good in the unit and not having access to a phone signal to call family was distressing. A relative also informed us that the health care assistants had good relationships with and provided excellent care to people on the unit, yet the staff nurses wrote all the care notes which they found confusing. We were informed that carers health and well-being should be fully considered in the discharge planning process when it impacts on the need for caring responsibilities to support discharges.

People in the unit described the food as excellent and everyone we spoke to told us they liked having their own room, and privacy. We were told there was not enough to do in the unit and the days could be long and boring, which they felt had an impact on a longer recovery journey and their sense of belonging in unfamiliar surroundings.

An individual told us about their trip out of the unit with the activity coordinator and how they enjoyed this, although they informed us this did not happen regularly. We heard that having access to the enclosed garden space was good, particularly when the weather was good.

We discussed the lack of activity at our meeting with senior managers after the visit. We were informed the activity coordinator works part time. A workload analysis tool was completed by the management team which concluded an activity coordinator 30 hours was required on the unit. The senior management team also informed us that the nursing team have tried to support and provide activities on the unit, however this depended on the clinical activity on the unit. We were also told by the management team that the ward has weekly anxiety management supported by psychology, and a weekly breakfast group- supported by occupational therapy.

The senior management team informed us that the improvement to the internet connection was imminent and recognised this as critical to the wellbeing and recovery of the individuals on the unit.

Care, treatment, support, and participation

Care records

All individual care records and care plans were stored on the electronic record system, EMIS. There was also documentation, such as information around medical treatment stored in paper records in the treatment room. We found EMIS easy to navigate and most continuation notes were informative and linked to care plans.

Care plans

We saw examples of care plans that provided a person-centred account of individual needs and subsequent interventions and found these linked with the information that was gathered from admission. There was evidence of care plans being regularly reviewed.

In the care plans, we would have preferred to have seen evidence of engagement with the individual and wider family where relevant and evidence of an individual being offered a copy of their care plan. We were pleased to find the content of care plans gave the reader a good account of the individual's current and historical needs, which was helpful for staff who may not be familiar with an individual, or aware of their presentation or circumstances.

We found detailed and person-specific care plans in place for each person, relating to mental health and physical health. It would have been beneficial to have seen discussions reflecting an individual's involvement and participation recorded during reviews in continuation notes or documented as a one-to-one meeting in the person's file.

Recommendation 1

Managers should ensure there is evidence of the person and relevant proxies being fully include at all stages of care planning and evidence of the person being offered a copy of their care plan.

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.

There was a robust approach to discharge planning in the unit with the consultant and senior unit staff being an active part of this process, attending discharge meetings as appropriate.

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

Multidisciplinary team (MDT)
The unit had input from a wide range of professionals who contributed to an individual's care and treatment. We were told that there was one consultant psychiatrist who covered the unit and that a weekly MDT meeting took place.

The MDT consisted of consultant psychiatrist, junior medical staff, a senior charge nurse, a charge nurse, occupational therapy input and a senior nurse. A social work representative and a social work representative regularly attended the MDT. There was also input from pharmacy at the meeting.

We found there was good attention to the link between physical and mental health care in the individual records. Staff told us that individuals had regular access to allied health professionals, such as dietetics and physiotherapy.

We were told that most individuals admitted to the unit had a formulation developed by the psychologist, which we felt was positive. Formulation is a structured approach to understanding factors underlying distressed states and behaviours. This process can allow the MDT to make sense of a person's difficulties by learning about key experiences in their lives and identifying individualised measures to support them.

We were told that there had been an electronic MDT document (SCAMPER) used during the Covid-19 pandemic, which was no longer in use. SCAMPER is a structured clinical assessment and communication tool intended to highlight key clinical tasks that needed to be completed for individuals and to ensure that their care progresses without gaps or delays. We were told that there was now a unified approach across Tayside in relation to psychiatry of old age inpatient MDT documentation. We found the document was clear and considered an individual's discharge. However, we also found gaps in reviewing and recording actions and progress in a file we looked at.

We asked about individual participation or involvement at the MDT meeting. This was an area that people on the unit and their relatives felt did not include them as fully as they would have wanted to be. We were informed that individuals and their relatives could attend the meeting. They could also meet with the doctor out with the meeting if they preferred. We were unable to find evidence of this recorded in the files we looked at.

Recommendation 2
Managers should review the current MDT documentation and ensure the record captures the MDT weekly discussion, with the recorded actions and outcomes, including the individual's views and their relative or legal proxy's views as appropriate, about their care and treatment.

Risk assessments
We saw risk assessments that were detailed and provided good historical information; and where appropriate there was a psychology formulation plan to support the recovery of individuals on the unit.

Discharge planning
There was a robust approach to discharge planning within the unit with the consultant and senior unit staff being an active part of this process, attending discharge meetings as appropriate within Tayside.

Use of mental health and incapacity legislation

On the day of our visit, four patients were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act), and we found the documentation that related to an individual's legal status was in order and easily accessible.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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. Paper copies of these were stored in the treatment room, to allow for easy access when dispensing medication. We did find multiple copies of these in each file; however, this was confusing and would recommend a system to audit all treatment certificates.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. In the unit, we did not find any named persons in place. We discussed this with staff who informed us that often when a person was detained under the Mental Health Act, they are not well enough to nominate a named person, although this was discussed at the time of detention by the responsible medical officer (RMO).

For patients' who had a legal proxy appointed under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act), we saw copies of the legal order in place.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan 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, who has relevant powers and record this on the form.

We found that while s47 certificates were in place, older obsolete copies were still held in the paper file, along with the newer one, which was confusing. The s47

certificates that we looked at were not fully completed as there was no evidence of a discussion with family or legal proxies. We brought to the attention of the senior managers during our meeting after our visit.

Recommendation 3
Managers and medical staff should develop an audit system to ensure only the current treatment certificate (T2, T3, s47) are kept in the paper files and that s47 certificates are fully completed to evidence proxy involvement, ensuring treatment is legally authorised where appropriate.

Rights and restrictions

The door to the unit was locked and we were told that some individuals, due to their vulnerability and progression of their illness, would be at risk if the door was opened. The unit had information about the door being locked outside the ward. It was our view that the locked door policy should also be clearly displayed inside the ward. This matter was to be addressed as a priority at the last visit and requires urgent action. We followed this up during our visit and were assured that this information would be displayed so that individuals on the unit or those visiting could see it easily.

For individuals who had covert medication in place, we were pleased to see that all appropriate documentation was in order, and easy to follow.

During our visit there was one person who was subject to seclusion. While we do not advocate the use of seclusion as a first-line response to behaviours that challenge in detained people and must only be used in the context of an approved policy on the management and prevention of violence, produced by the relevant NHS board for each hospital, we do, however, acknowledge its use and will review when this is place to ensure that it is properly monitored with the aim of reducing risk. The principles of least restriction and benefit to individuals must be always applied and it is also important to support and debrief the person after an incident of seclusion. When reviewing the care of the individual who was subject to seclusion, we found it was care planned effectively and reviewed accordingly.

The Commission developed use of seclusion as a good practice guide in October 2019. This guidance was written for situations where those professions may be considering using seclusion pathway treatment.

Where individuals had been detained under the Mental Health Act, we found that they had been provided with information about their rights and had access to advocacy services which was positive. For individuals who were informal, they were less aware of their rights during their hospital stay.

When we were reviewing each individual's files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under

sections 275 and 276 of the Mental Health Act and are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We did not find any advance statements and were informed this was due those who were on the unit at the time of our visit not being well enough to complete them or not wishing to complete one. Nevertheless, we would expect to have seen documented discussions about advance statements in the care records for individuals who had chosen not to complete them.

The Commission has developed *Rights in Mind.* 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

The unit had an activity coordinator who worked three days per week and who provided activities on a one-to-one or group basis. There was also a volunteer who visited the ward fortnightly.

We looked for evidence of activity planning to see if activities were linked to care goals, and whether it had been recorded and evaluated. We found the recording of activities was limited and we heard from meeting individuals and relatives that the activities were viewed by them as “poor”, except for an odd walk outside with the activity coordinator. The senior management team recognised the importance of activities for recovery and hoped to increase the activity coordinator role in the unit.

We did not see a visual planner in place in the unit so that individuals would know what and when activities were due to take place. Individuals told us about they enjoyed their time out of the unit with the activity coordinator. We did not see evidence in care records of the benefits of participation in therapeutic activities or if they have been offered and declined. Therapeutic activities are important to support an individual’s recovery. We noted that there were more activities happening in the unit, but that these were not being recorded.

Recommendation 4

Managers should ensure that all activities are recorded and linked to individual care plans, with a record of the benefit of the activity to the individual as well as non-engagement.

The physical environment

Rowan unit was a purpose-built unit that opened in December 2011. The unit was very well maintained, clean and has lots of space for purposeful walking that supported exercise for all individuals in the unit.

All the rooms were single, ensuite rooms and were immaculate. The unit had a secure garden area that was well maintained and easily accessible. There were occasions when individuals in the unit vaped in the garden, and while this was not encouraged, it was still permitted. We were informed that alternatives to smoking and vaping were offered.

Recommendation 5
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

Individuals told us that they enjoyed the outdoor garden and that having their own rooms provided privacy.

The unit had an activity room, communal lounge and separate dining area and there were other seating areas throughout the unit that offered a quieter space. There was a laundry room that individuals could use, with staff supervision, to do their own washing whilst in hospital.

We would have liked to have seen an activity board on the wall and information that included access to advocacy services to ensure those who were on the unit, and relatives, had as much information as possible. We did note there was information in relation to carers outside the unit door which was helpful for relatives who visited the unit.

The unit had been part of the anti-ligature reduction programme across NHS Tayside. We were told that some of the works had already been completed, with other worked planned as part of Tayside health board's improvement plan.

Summary of recommendations

Recommendation 1
Managers should ensure there is evidence of the person and relevant proxies being fully include at all stages of care planning and evidence of the person being offered a copy of their care plan.

Recommendation 2
Managers should review the current MDT documentation and ensure that the record captures the MDT weekly discussion, along with the recorded actions and outcomes, including the individual views and their relative or legal proxy's views as appropriate about their care and treatment.

Recommendation 3
Managers and medical staff should develop an audit system to ensure only the current treatment certificate (T2, T3, s47) are kept in the paper files and that s47 certificates are fully completed to evidence proxy involvement, ensuring treatment is legally authorised where appropriate.

Recommendation 4
Managers should ensure that all activities are recorded and linked to individual care plans, with a record of the benefit of the activity to the individual.

Recommendation 5
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and therapeutic environment for all and ensure that staff are given support to manage this.

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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