Mental Welfare Commission for Scotland

Report on announced visit to: Adult Rehabilitation Wards, (Craiglea and Myreside), Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 1 August 2019

Where we visited

Craiglea and Myreside are adult rehabilitation wards, based in the Royal Edinburgh Hospital. Craiglea is a 15-bedded male ward, Myreside has 15 beds for female patients. We last visited these services in June 2018, as part of the rehabilitation themed visit. Prior to that, we visited the wards in May 2016 and recommended that the care plans addressed patients' mental health needs, that summative evaluations, reviews of care plans, and an audit process should take place. It was also recommended that information about the locked door be made available and that environmental issues, noted on the day of the visit, be addressed.

Since the visit in 2018, both of these units have moved to their current location in April 2019. This announced visit was to meet with patients, review the changes to the environment, in addition to following up on the previous recommendations.

Who we met with

We met with and reviewed the care and treatment of 11patients and spoke to one carer.

We met with the clinical nurse manager, the senior charge nurses and charge nurses for both units, as well as other members of nursing staff and student nurses on placement.

Commission visitors

Moira Healy, Social Work Officer

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

Susan Tait, Nursing Officer

What people told us and what we found

Those that we met with on the day were positive about the staff that worked with them. We heard that staff are encouraging, supportive, helpful, and provide patients with opportunities to engage in a range of activities that promote their rehabilitation.

We were told that there were aspects of the new environment that were an improvement from the previous rehabilitation wards, although for some, remaining in hospital and having to accept prescribed medication was an issue for them.

We heard that there were opportunities to be involved in discussions about care and treatment with a range of professionals involved in patients' care, and that there was support specifically for relatives. We found that the care provided by the nursing and clinical team was done in a compassionate and empathetic way; we could see that there were significant challenges in engaging and motivating the patients in the ward due to the complexity and chronicity of their mental health needs, but could see the positive outcome of the ongoing work in these wards.

Care, treatment, support and participation

In reviewing the care and treatment, we found good evidence of this in detailed and well organised care plans. We were pleased to see that the previous recommendation about the patients' mental health needs has been addressed and we noted that, along with a comprehensive history of the individual, the care goals were personalised and described that person's needs. The goals were then incorporated into one-to-one sessions described in the electronic progress notes, which then were evaluated in the three monthly reviews. The rehabilitation service at the Royal Edinburgh Hospital uses an integrated care pathway (ICP) approach with their care plans. The two parts of this process – the first being completed within a month of admission and the second which is used for the three monthly reviews are an integral part of the care plan. We found that all of the patients that we reviewed had up-to-date ICPs and the level of detail in these was of a standard that we would recognise as good practice, as defined by our guidance on care planning. This can be found at: www.mwcscot.org.uk/sites/default/files/201908/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

The ICP care plans that we reviewed contained details on the involvement of psychiatry, ands psychology, with links to formulation and psychological interventions, occupational therapy and other allied health professional where referrals had been made. We found good evidence of physical health care monitoring, including a review of medication, physical health care screening and intervention, as well screening tools such as the Camberwell assessment of needs (CAN) and Glasgow Antipsychotic Side-effect scale (GASS).

In keeping with the use of a recovery and rehabilitative approach, we found that patients had recovery action plans, a recovery assessment tool, and support plans that identified short-term and long-term goals, focusing on the patients' strengths and what they wanted to achieve. We found evidence of patient participation and involvement in these, although in some cases it appeared as if the patient was making the statement, but using terminology that was not consistent with that individual's choice of words. On the day of the visit, we discussed this with the senior nurses and advised them to use one specific approach – either

the patient's words in "I will/would" statements or nursing interventions using the patient's name.

Evaluation of the goals and the rehab review of patient care were also clearly indicated in the ICP care plans. There was a helpful section on changes since the last review, and the identified goals had an outcome, which we noted had been rated by both staff and patient. There was a separate form that was used for reviews; again, we found these to be comprehensive in detailing all aspects of the patient's care, and there was evidence of what had been discussed with the patient and the actions for the clinical team.

Use of mental health and incapacity legislation

A number of the patients that we reviewed were subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). For all of these patients, we saw copies of the relevant forms under the Mental Health Act in their care plans. We also saw that there were certificates authorising treatment (T2 or T3 forms), however on the day of our visit, there was an issue with one of the T3 forms, which was addressed at the time.

There were patients who were under sections 281 to 286 of the Mental Health Act. We found that there were reasoned opinions in relation to the restrictions placed on the individuals, and that the need for the specific restrictions was regularly reviewed and documented accordingly.

There were also patients who were under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). We found the relevant guardianship orders in the care plans and for those patients who had been assessed as lacking capacity to consent, and were being provided with treatment under Part 5 of the AWI Act, section 47 certificates authorising treatment were completed. We found that one of the certificates did not have a treatment plan, and we raised this with staff on the day of the visit.

Rights and restrictions

Those that we spoke to told us that they had access to advocacy and had input in terms of legal advice when required. We were pleased to see that both parts of the ICP had a focus on patient's rights; it was recorded where patients had been made aware of their rights in terms of both the Mental Health Act and AWI legislation.

We also found evidence of the use of advance statements, which we found in the patients' care files. We would encourage staff in both wards to continue promoting the use of these.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

There is a locked entrance to the units; however a lift is available for patients which enables them to enter the main reception area for Craiglea and Myreside. The main door to Craiglea, the ward for male patients, is locked. Patients are made aware of this at the time of admission, there are signs indicating that a locked door policy is in operation, and this is available for those who wish to review it. There is a seating area at the entrance to both wards, and we

were advised that a member of staff is in attendance there throughout the shifts; we were able to observe this on the day.

Activity and occupation

We found evidence of a broad range of rehabilitation activities that are offered to the patients in Craiglea and Myreside. There were activities that promoted physical wellbeing, occupational, educational, psychological, social and recreational skills for both male and female patients. These ranged from daily activities such as cooking, breakfast/lunch groups to football and gym sessions, bee keeping and gardening to name some of events that we found on the weekly planner and in patients' care plans. Both units had activity boards detailing what was scheduled, tailored to the needs of the patients and we were pleased to see that student nurses were actively supporting the development of this in Myreside Ward. Activities are reviewed through the ICP process, and there is a timetable in each care plan, and for those patients that benefit from it, one in their room.

We were made aware that activities are delivered by occupational therapy, psychology and activity coordinators, as well as the nursing team. We heard that due to staffing issues in other parts and services in the hospital, nurses are re-deployed to other clinical areas, which has an impact on the level of activity offered for patients in the units.

Recommendation 1:
Managers should ensure that rehabilitation services and staffing numbers are adequate to allow for planned activities.

The physical environment

We were pleased to see the significant changes to the environment for both Craiglea and Myreside. Since moving to the new wards, one main difference has been in having one ward solely for males (Craiglea) and the other for females (Myreside), which has been a positive step. We could see that there are marked improvements in the decor, in the size and space of different rooms such as the kitchen/dining area, living rooms and in the patient bed areas. While some of the bed areas are shared, efforts have been made to separate them with screens and furniture. There was an issue with the privacy windows on the doors, although we discussed this at the end of visit feedback, where a potential solution has been identified.

There is an issue with the unit being on the second floor; patients cannot readily access an outdoor area. We noted that there is an issue with smoking on the ward, and for those patients that choose to smoke, this in part may be due to difficulties accessing an area where smoking is permitted. We were advised that staff continue to promote smoking cessation programmes and a smoke free environment.

The other difficulty with being on an upper floor, is that there is no access to a garden area. The current provision is overlooked and undulating. There is a fenced garden area, but this is only accessible to those in Craiglea and would not be suitable for those with mobility issues.

Recommendation 2:
Managers should review the provision of outside space and garden areas for both Craiglea and Myreside Wards, and develop a more appealing outdoor area for patients.

Summary of recommendations

1. Managers should ensure that rehabilitation services and staffing numbers are not depleted to the extent where activities for patients are reduced.

2. Managers should review the provision of outside space and garden areas for both Craiglea and Myreside Wards, and develop a more appealing outdoor area for patients.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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

ALISON THOMSON
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 MWC 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 individual care, treatment and support is 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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