



## **Mental Welfare Commission for Scotland**

**Report on announced visit to:** Robert Fergusson Unit, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

**Date of visit:** 31 July 2019

## **Where we visited**

The Robert Fergusson Unit is the Scottish Neurobehavioural Rehabilitation Service National Inpatient Unit. It provides inpatient rehabilitation for people with acquired brain injury whose symptoms include severe behavioural disturbance. The 20-bedded unit can also support patients with progressive neurological conditions such as Huntington's disease when specialist psychiatric care is required.

We last visited the service on 18 September 2018. On this visit significant concerns were raised with us by patients, carers and members of the multidisciplinary team (MDT) about staffing levels and the impact this was having on patient care. We were told this was affecting the provision of safe observation across the ward environment, and of specialist rehabilitation support. Given the level of these concerns, we escalated the issues to senior managers within NHS Lothian who subsequently appointed a review board to look at the needs of the service and develop action plans to address the Commission's recommendations. Our recommendations related to staffing, improvement in rehabilitation focussed activity, and addressing noise levels on the ward.

On the day of this visit we wanted to follow up on these recommendations and to hear from patients, carers and staff about their current experience on the unit.

## **Who we met with**

We met with and/or reviewed the files of eight patients and spoke with two relatives (one by telephone prior to the visit). We met with the deputy chief nurse for Edinburgh Health and Social Care Partnership, the newly appointed clinical nurse manager for the unit, the senior charge nurse, charge nurses, and outreach nurse. We spoke with other members of nursing staff and healthcare assistants. We also met with the speech and language therapist and the associate specialist on the unit.

## **Commission visitors**

Dr Juliet Brock, Medical Officer

Moira Healy, Social Work Officer

Paula John, Social Work Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

On the day of our visit there were 12 patients on the ward. A number of patients had recently been discharged and a new admission was awaited. A reduction in bed use was enabling patients with more complex needs to be admitted. We were told that patient numbers were being kept under review and all new admissions were considered in the context of clinical need and staffing requirements.

Throughout the visit we observed warm interactions between staff and patients. It was evident from discussions of individual cases that nursing and medical staff had detailed knowledge of the patients in their care and a holistic view of each person's strengths as well as the challenges they faced.

The patients we met who were able to tell us about their experience were positive about the staff and the care they were receiving.

The carers we consulted were also positive in general about their relative's care. Individual concerns were raised in one case, which we discussed with senior staff on the day.

### **Staffing**

It was evident that significant progress had been made in the ten months since we last visited the service. We were told that managers were more visible and accessible to the clinical team and that their focus on improving patient and staff experiences had been highly supportive. Staff said their concerns were being listened to and they felt their views were valued. The recent appointment of a clinical nurse manager for the service was welcomed by the team.

We were told of recent practical changes that had also improved the day-to-day running of the ward. These included the nursing office being relocated in the main ward area and changes in how nursing shifts were run, with a single team now caring for all patients, overseen by a shift co-ordinator. The team felt this had improved communication.

The service review was also experienced as positive. Staff told us they were being consulted throughout the process and were represented on the review board. Although the scope of the review was more extensive than originally anticipated, with the process likely to take longer as a result, the team generally welcomed this.

With regard to staffing, managers recognised that a third of the nursing team had left the service in recent years and were supporting a focus on recruitment and retention. The team plans to advertise at a national level, and had successfully appointed a number of new nurses to the team. The clinical team told us that an improvement in staffing levels had led to clear improvements in patient care. Staff now had more time and opportunity to provide specialist rehabilitation, supporting individuals to progress towards discharge. Four patients had been successfully discharged in recent months.

We were told there was also an enhanced focus on staff training. Training days were being planned and arrangements put in place to support staff to attend. A mentoring system is also in place to support new staff. There were additional plans for staff to access specialist skills

training such as positive behavioural support (PBS) courses and RAID (Reinforce Appropriate, Implode Disruptive) behaviour training. These approaches can help in the management of challenging behaviours.

It was acknowledged that, due to the complex nature of some patients' difficulties, levels of violence and aggression on the ward remained high. Serious adverse event reviews were being carried out in relation to specific incidents and the Commission will review these when the reports are complete. In relation to violent incidents, managers were addressing both issues of patient safety and the support needs of staff. Debriefing sessions had been introduced, offering staff both support and learning opportunities when incidents occurred. Managers were also looking to introduce additional measures to enhance staff wellbeing on the ward.

Objectively, there appeared to have been a positive shift in culture, with staff saying they feel supported and valued. The staff we spoke with felt there had been a marked improvement in morale as a result. The supportive approach by managers was commented on and welcomed by all those we consulted. It was acknowledged that improvements were still needed, but there was confidence from the clinical team that this could be achieved with a consistent approach.

## **Documentation and care plans**

The case files we reviewed were well-organised, with documents easy to find.

Care plans were person-centred, detailed, and contained useful background information about the individual and were regularly reviewed. Care plan reviews were documented by date, but did lack narrative detail. We felt this could be improved. Patient participation in the care planning process also appeared limited and we discussed with senior staff whether this gap might be bridged with advocacy support, particularly for those who would struggle to express their views.

The Commission have just published good practice guidance on person centred care plans which the team may wish to review:

[https://www.mwscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans\\_GoodPracticeGuide\\_August2019\\_0.pdf](https://www.mwscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf)

Weekly MDT meetings were well-documented. Three-monthly review meetings, where patients' progress was formally reviewed with the participation of external professionals and family members, were also comprehensively and clearly documented with action points following on from meetings. The addition of goal-setting meetings and detailed progressive and maintenance support plans provided a clear narrative of each patients changing needs and the progressive focus of treatment and rehabilitation.

We found evidence of annual physical health reviews. One area we felt would benefit from better recording was patient engagement in activities on a day-to-day basis. Senior staff agreed to review this. Managers recently submitted a proposal for funding to appoint a full-time activity co-ordinator for the service. The unit is still under review at present awaiting recommendations. This request is currently being considered but has not been acted on as yet, if successful, this could also help improve the recording of patient participation in activities.

## **Use of mental health and incapacity legislation**

With the exception of one individual, all patients were receiving care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Copies of Mental Health Act documents were available and easily located in patient files.

We reviewed all prescribing and authorisation for treatment under the Mental Health Act. We found some instances where prescribed medications had not been properly authorised on a T2/T3 certificate. In each case this related to 'as required' (PRN) medication. We highlighted the errors with the associate specialist on the day so that this could be promptly resolved.

Where individuals were subject to welfare powers under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), copies of the powers were not available in all the files we viewed.

Where patients lacked capacity to consent to their physical health treatment, we found appropriate use of the AWI Act with s47 certificates and individual treatment plans in place to authorise treatment. We recommend that s47 certificates are filed alongside patients' prescription charts, so that prescribers and nurses dispensing medication could easily check the authority for providing treatment. We discussed this with senior staff on the day.

### **Recommendation 1:**

Managers should ensure that patients receiving treatment under the Mental Health Act have all prescribed medication properly authorised and regular audits are carried out to check T2/T3 certificates with prescribing.

### **Recommendation 2:**

Managers should ensure that for all individuals subject to welfare powers under the AWI Act, copies of legal powers are recorded in patient files.

## **Rights and restrictions**

In the files we reviewed we found limited documentation in relation to patient rights. As mentioned previously, we suggested that advocacy is used where appropriate to support patients in the care planning process.

We were told that few patients had advance statements. This is another area where advocacy could be used, particularly for patients progressing towards discharge, to support them making their future treatment wishes known.

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>

## **Activities**

We noted an improvement in activities since our last visit. Nursing staff told us they were able to take patients out more, including accessing activities on site such as The Hive or the Cyrenians Gardening Project. This had previously been difficult due to staffing constraints. Healthcare assistants also told us they had more opportunity to engage patients in meaningful

activities both on and off the ward. We were told that recently enthusiastic third year nursing students had also been instrumental in supporting individual patients in recreational activities.

At the time of this visit, scheduled activities included a weekly visit by a therapist and a fortnightly music event at the Hive, solely for patients from the Robert Fergusson Unit. Patients who were more able were being supported to access the local community. There had been a few minibus outings since our last visit.

Patients had individual timetables for activities. Occupational therapists, the art therapist, speech and language therapist and a physiotherapist supported individual and small group and activity/therapy programmes.

There was a clear shift towards improving activities and rehabilitation for patients on the unit, back to a level successfully achieved in former years. The recent improvements appeared to have been enabled largely by changes in staffing capacity since our last visit. The need for further activity provision was however recognised, particularly for those patients restricted to the ward environment. We were pleased that managers had made an application to fund an activity coordinator for the ward, and would fully support this plan.

## **The physical environment**

During the previous visit we were made aware of some significant challenges posed by the new ward environment. Observation in some corridors was a particular concern. We were asked about CCTV installation and gave advice of the measures needed if this was to be pursued. We were told on this visit that there are no plans to install CCTV. Instead, mirrors have been installed in some of the communal corridors where visibility had been a concern. Live link monitors are used to alert staff on enhanced observations when it is deemed confident and appropriate for patients to spend time on their own, by alerting staff when a patient leaves their room. For some individuals this had been assessed to reduce the need for direct observation, without compromising patient safety.

Problems with noise, particularly in the open plan dining/sitting room, had been highlighted in our last visit. Nursing staff and members of the therapy team informed us that noise levels in this area, particularly during meal preparation and serving, remained a significant problem. We were told that mealtimes were stressful for patients and staff for this reason. Concerns about choking risks for some patients remained a particular concern in this context. We again discussed environmental noise reduction measures that could ameliorate the problem. We were told of hopes to seek funding for this. As an interim measure we also discussed potential changes in meal planning which could assist the team, having seen this successfully used by other services with similar challenges.

We were advised that the partition in the sitting/dining area, which is currently restricting space, is due to be removed.

We were pleased to see that patients and staff had selected some artworks for the walls. This provided visual interest and made the environment appear less clinical. We were pleased to hear of plans to continue this procurement.

### **Recommendation 3:**

Following our previous recommendation about excessive noise on the ward, we recommend that managers urgently review this issue and implement measures to reduce the problem.

## **Summary of recommendations**

1. Managers should ensure that patients receiving treatment under the Mental Health Act have all prescribed medication properly authorised and regular audits are carried out to check T2/T3 certificates with prescribing.
2. Managers should ensure that for all individuals subject to welfare powers under the AWI Act, copies of legal powers are recorded in patient files.
3. Following our previous recommendation about excessive noise on the ward, we recommend that managers urgently review this issue and implement measures to reduce the problem.

## **Good practice**

### **Outreach work**

We were pleased to hear of the progress the service had made with outreach work this year.

Since our last visit, the outreach nurse had been able to undertake her role full time. The main focus of her work had been building relationships with care facilities across Scotland and supporting local staff with training when individual patients were being discharged to their care. The outreach nurse was also working closely with carers, inviting them to visit the unit before their family member was admitted and later supporting them throughout the discharge process. The team were keen to ensure that patients experienced successful transitions home. Careful planning and close liaison pre and post-discharge helped ensure that local care providers, community services and carers were supported during the patient's transition from the regional unit back to their home area. Each patient's bed is also kept open for a month post-discharge in case difficulties arise; this is supported and funded by the individual's NHS Board.

We heard that a number of newly-referred patients had also been supported in the community by their local team, with the help of outreach nurse. This had prevented some patients requiring admission to the unit (including, in some cases, individuals living in the highlands and islands). In a few cases, a small team from the unit had provided a period of brief intensive outreach, successfully supporting an individual to remain at home with local health supports. The team are keen to continue and further develop this outreach approach, enabling a new level of flexibility in the provision of national specialist care.

This brief intervention model is an innovative approach, particularly for patients living in remote and rural areas. We were told that this approach is now being considered by national brain injury networks and by health boards who would benefit from this model of care. We look forward to hearing how this work progresses in the future.

## **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.

**Contact details:**

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

**telephone: 0131 313 8777**

**e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)**

**website: [www.mwscot.org.uk](http://www.mwscot.org.uk)**

