Mental Welfare Commission for Scotland

Report on announced visit to: Cedar and Hawthorn Wards, Orchard Clinic, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 10 September 2019

Where we visited

The Orchard Clinic is a 40-bedded, medium secure forensic unit on the Royal Edinburgh Hospital campus. In addition to an acute admission ward, there are two forensic rehabilitation wards within the clinic. Cedar is a 14-bedded rehabilitation ward for men. Hawthorn is a mixed-sex rehabilitation ward, with 13 beds.

We last visited the rehabilitation wards at the Orchard Clinic on 28 August 2018 and made recommendations for a review of activity provision and the provision of female-designated areas on Hawthorn Ward.

On the day of this visit we wanted to follow up on the previous recommendations and to meet with patients to hear their experiences.

Who we met with

We met with and/or reviewed the care and treatment of nine patients. No carers/relatives/friends asked to meet with us.

We spoke with the senior charge nurses of both wards and other members of the nursing team.

Commission visitors

Juliet Brock, Medical Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of this visit there were 13 patients on Cedar Ward and 11 patients on Hawthorn Ward, two of whom were female.

The patients we met with spoke positively about the care they received. A number of patients on Cedar Ward highlighted how staff had supported them to access a range of activities, individually tailored to support their recovery and rehabilitation.

As with previous visits, we observed staff as caring and respectful towards patients. It was evident from our discussions with nursing staff on both wards that they were knowledgeable about the patients in their care and were striving to deliver individualised treatment and support.

The team continue to have input from a peer support worker and both patients and staff spoke very positively about the contribution this made to individuals' care.

Information on patient files was held largely on TRAK, the online system in use across NHS Lothian. Some documents remained incompatible with TRAK and were stored separately. This discrepancy remained a challenge for the clinical team.

The wards across the clinic had very recently introduced new care planning documents. These had been designed to encourage patient involvement in the care planning process and to focus on individual support needs and recovery goals. It was too early to assess how the new documentation was working in practice, but we look forward to reviewing this in future.

We saw good evidence of multidisciplinary team (MDT) input in patient files, with clear documentation of discussion and decision making at reviews. Weekly risk monitoring and supervision (WRMS) documents and care programme approach (CPA) records provided a high level of detail. We saw good examples of physical health monitoring.

Each consultant team has input from occupational therapy and psychology. Input from pharmacy, dietetics and physiotherapy is available when required. The clinic also has input from art and music therapists.

On previous visits, the nurse therapy team within the clinic provided a range of psychological therapies. With the support of the lead nurse, and supervision from psychology, nursing staff had opportunities to develop specialist therapeutic skills. At the time of this visit, the lead nurse post for the team was vacant and due to be re-advertised. Because of additional staffing pressures across the clinic and increased difficulties with recruitment across the site, we were told there was limited opportunity for staff to provide specialist therapeutic interventions, with groups such as Hearing Voices and DBT not able to be run. We advised that any restriction on patients' activities and therapies should be monitored.

Use of mental health and incapacity legislation

All patients were detained under the Criminal Procedures Act or the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

We reviewed the consent to treatment forms (T2) and certificates authorising treatment (T3) for every patient. These were appropriately filed alongside each patient's prescription sheet, but we found a few instances where patients were prescribed medications that was not properly authorised under the Mental Health Act on a T2 or T3 form. These cases were highlighted with staff on the day so that each patient's consultant would be notified.

In accordance with the Adults with Incapacity (Scotland) Act 2000, a Section 47 certificate had been completed for a patient who lacked capacity to consent to their physical health treatment and, in line with good practice, an individualised treatment plan accompanied this.

Recommendation 1:
Managers should arrange for audits to be carried out on a regular basis to ensure that every patient's prescribed medication is properly authorised on a T2 or T3.

Rights and restrictions

We heard from both patients and staff that there continues to be a high level of support from advocacy services. Individual patients told us they had received support from advocacy and legal representatives to make appeals, including appeals about detention in conditions of excessive security.

A number of patients told us they had made advance statements. Others had declined, but staff were aware where this was the case and told us that advance statements were discussed with patients and encouraged.

We heard from senior nurses in both wards, and from some patients themselves, that they were ready to move on from the Orchard Clinic, but their discharge had been delayed due to lack of available provision in low secure care or in the community. At least five patients were awaiting discharge at the time of this visit. We are following up individual cases where discharge has been significantly delayed. We were advised that the problem of delayed discharge was also impacting on the ability to admit patients to the clinic as a whole. Seven patients were awaiting admission to the clinic when we visited.

The Commission is concerned about delayed discharge from forensic services across Scotland and will liaise with managers to request regular updates on waiting lists for admission and delayed discharge.

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/rights-mind/

Activity and occupation

On our last visit, we noticed a difference in the activity programmes between the two rehabilitation wards, with less apparent opportunity for patients to engage in structured activity on Hawthorn. We recommended that managers review the needs of patients on Hawthorn ward and consider whether the appointment of an activity co-ordinator would be of benefit.

The appointment of an activity co-ordinator remained under consideration at the time of this visit. We were pleased however to see the results of significant efforts by the staff team to improve this aspect of patient care over the previous year. An activity plan, with a timetable for ward based groups, had been put in place, with one member of the team taking a lead in planning activities. We heard about the positive benefits this was starting to have, particularly for individual patients who had previously been reluctant to engage in groups or activities. We heard that this was an aspect of care that the team on Hawthorn were keen to continue to develop and improve.

Cedar Ward continue to have an activity nurse in post. The feedback from both patients and staff on activity provision remained very positive on Cedar. There was a full timetable of activities and individual patients had highly personalised programmes, combining a wide range of activities both within the hospital and in the community. This included volunteering work and educational opportunities. Patients told us their timetabled activities were very much tailored to their individual interests and objectively activity provision had a strong recovery focus.

Recommendation 2:
Managers should review how they can best support the continued development of activities for patients on Hawthorn Ward, to ensure greater equity of provision across the rehabilitation service.

The physical environment

When we last visited the clinic, problems with the heating system had caused serious concern. We were aware that work had been undertaken to carry out repairs. Staff advised us that there had been no further incidents arising from heating problems. We welcomed plans that staff and managers would continue to monitor this over the winter and notify the Commission if any concerns arose.

Since our last visit there had been cause to review security measures across the clinic. We heard about a significant programme of improvement work that had been completed and we were able to see changes that had been made to the environment, including to individual bedrooms.

We were pleased to hear that in response to some of these issues, a multidisciplinary Senior Management Working Group had been set up to continue to review the clinic environment. We were told that in addition to addressing maintenance issues as they arose, the group wanted to look at how medium secure care on the REH site might best be provided in the future. The Orchard Clinic was built in 2001 and on recent visits we have heard consistent concerns from staff and managers about the fabric of the existing building. Questions have arisen about how the current environment will continue to meet the needs of the patient group in the future. We look forward to hearing how the working group is progressing these matters on future visits.

At present, the general environment and decor of both wards, although tired in places, remains of an acceptable standard. We were disappointed however by the upkeep of the outdoor space. Although the shared garden provided places to sit, the space lacked interest, was not well-cared for and did not offer an inviting outdoor environment for patients to enjoy. More

concerning was the large fenced outdoor basketball/football court, which was in a state of neglect and partly filled with disused furniture and discarded equipment. This could provide an enjoyable recreational space for patients and one that could encourage physical activity. We discussed this with both charge nurses on the day. We were assured that the teams would make arrangements for the space to be cleared to enable it to be fully used by patients.

One area we have repeatedly highlighted in the past has been the lack of gender-sensitive accommodation in the Orchard Clinic, with lack of female designated areas in mixed wards. There remains a lack of female-only space on Cedar. We are aware that proposals have been made for some years to establish a female-only ward at the Orchard Clinic. It is disappointing that no progress has been made in realising these plans. We understand this is due to lack of funding being made available.

In the absence of any current plans for a female-only ward, we would ask again that managers review the needs of female patients on Hawthorn Ward and advise the Commission whether their needs are being met currently. If the provision of female-only areas on the ward would be of benefit, an action plan should be put in place to meet this need.

The Commission is aware that the lack of appropriate provision for women in medium secure care is also a national resource issue. The Commission are continuing to raise concerns about this gap in provision with the appropriate forums.

Summary of recommendations

1. Managers should arrange for audits to be carried out on a regular basis to ensure that every patient's prescribed medication is properly authorised on a T2 or T3.
2. Managers should review how they can best support the continued development of activities for patients on Hawthorn Ward, to ensure greater equity of provision across the rehabilitation service.

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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