mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Redwood Ward, Orchard Clinic, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 11 September 2019

Where we visited

The Orchard Clinic is a 40-bedded, medium secure forensic unit on the Royal Edinburgh Hospital campus. Redwood is a 15-bedded acute admission ward for both men and women.

There are two forensic rehabilitation wards within the clinic: Cedar, a 14-bedded rehabilitation ward for men, and Hawthorn, a 13-bed mixed-sex rehabilitation ward. The Commission have visited and reported on the rehabilitation wards separately.

We last visited Redwood ward on 25 April 2018 and made recommendations for: a review of systems for keeping online records; for urgent heating repairs to be undertaken, and for the garden environment to be reviewed.

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 six patients. No carers/relatives/friends asked to meet with us.

We spoke with the senior charge nurse and members of the nursing team.

Commission visitors

Juliet Brock, Medical Officer

Moira Healy, Social Work Officer

Graham Morgan, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

On the day of this visit Redwood Ward was full. Of the 15 inpatients, only two were women.

The patients we met with generally spoke positively about the care they received. One patient commented they had recently been asked if they were happy with how they were being treated; they welcomed this question and said it gave them recognition. The individual told us they were very happy with how they were being treated. Other patients spoke positively about participation in their care, with regular opportunities to meet with the clinical team and discuss their treatment. They welcomed being included in decisions making.

We received comments from two patients about negative attitudes from a few individual ward staff, with examples of conduct that was concerning. We spoke with the senior charge nurse on the day, who was deeply concerned to hear this. We were advised that the concerns would be raised with the staff team and addressed with any individuals involved. We advised the patients involved to speak to the charge nurse about any concerns and to raise these issues with advocacy, who could offer support and assist in making a complaint if wished.

As with previous visits, the interactions we observed staff having with patients on the day were warm, caring and respectful. Staff whom we spoke with had a good knowledge of the patients in their care when we discussed individual cases. The philosophy of the team is to provide recovery-focussed patient-centred care. We were told that the ward has quite a high turnover rate, with many individuals being admitted for assessment and discharged within a month, often to the community. The patient group often have complex and diverse needs. Occasionally the ward has long-stay patients due to lack of appropriate provision available for them to move on to. At the time of this visit, seven patients were on a waiting list for admission to Redwood Ward. Five of those patients were waiting to move from high security to medium secure care.

There continues to be a strong multidisciplinary focus in the care provided on Redwood Ward, and across the Orchard Clinic. Each consultant team has input from occupational therapy and psychology. Additional expertise from pharmacy, dietetics and physiotherapy is available when required, and the clinic also has input from art and music therapists. There is a peer support worker in post and we continued to hear positive feedback about the success and importance of this role from both patients and staff.

Patient Records

On the last visit, we raised issues about information on patient files being held variously on the online TRAK system and in paper files, which was a challenge for staff. As the TRAK system is Lothian-wide, it has not been possible for adaptations to be made. Clinical documents such as care plans, for which formats are not supported by TRAK, are now held separately in electronic format. Staff told us that this did mean that records remained fragmented, but no other solution had been found. The Commission are aware that this has now become a wider challenge as TRAK has been adopted across mental health services in NHS Lothian.

At the time of this visit, the clinic had 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.

In the patient files we reviewed, there was good evidence of multidisciplinary team (MDT) input, with clear records of clinical team meeting discussions and decision making. Weekly risk monitoring and supervision (WRMS) forms and care programme approach (CPA) documents were detailed and also completed to a high standard.

Use of mental health and incapacity legislation

All patients were detained under the Criminal Procedures (Scotland) Act 1995 or the Mental Health (Care and Treatment) (Scotland) Act 2003.

We reviewed consent to treatment forms (T2) and certificates authorising treatment (T3) for the 11 patients receiving treatment beyond two months. One patient did not have a T2/T3 in place; this had been identified by the clinical team and was being rectified. Four patients had T2s and six had T3s in place. These were filed alongside each patient's prescription sheet, which is good practice.

We found two instances where a medication was prescribed but not authorised on a T3. This was highlighted with staff on the day to raise with the relevant consultants.

We also found two patients who had consented to their treatment and had a T2 in place, but who had been prescribed as-required psychotropic medication via the intra-muscular (IM) route that was not authorised. Neither patient had been given medication via this route. We asked that either the IM medication was removed from the prescription, or a DMP second opinion was sought for a T3 if this medication was required. It is the Commission's view that IM 'as required' medication should not be authorised on a T2. This is because in circumstances in which IM medication is likely to be given, it is unlikely that the patient would be giving their consent.

In accordance with the Adults with Incapacity (Scotland) Act 2000, a Section 47 certificate had been completed for one patient who lacked capacity to consent to their physical health treatment. 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 where this is required.

Rights and restrictions

We met some patients in the presence of their advocacy worker and their input was welcome. Staff commented on the excellent support provided by advocacy and a number of patients also told us how helpful they had found advocacy support.

In addition to individual advocacy, the Patients Council at the Royal Edinburgh Hospital hold collective advocacy meetings at the Orchard Clinic every few months and provide patient feedback to the management group. We were told that members of the nursing team also

hold community meetings on the ward to gather feedback and offer patients the opportunity to discuss any issues.

We saw Advance Statements in some of the patient files we reviewed, along with good evidence that these were referred to in individual care plans and informed patient care.

Several patients raised concerns with us about the restrictions they were placed under, due to limitations in passes or access to activities outwith the ward. Individual care plans and pass plans are informed by clinical risk assessment and we saw evidence that these were regularly reviewed, with levels of restriction minimised where possible.

Given the level of restriction for some patients, we did think there could be more focus on opportunities for meaningful activity and recreation on the ward. We discuss this further in the next section.

One patient raised concerns with us about an episode of restraint on the ward. The patient reported a traumatic recollection of this event and said that a debrief had not been offered from staff afterwards. The patient told us they had raised concerns with advocacy and were seeking legal advice on the matter. We spoke with senior staff about this on the day.

When a patient has to be restrained, for their own safety or that of others, we were told that a number of things happen afterward: a debrief takes place among staff, and an opportunity is also taken to discuss the restraint with the patient when they are in a calmer state. Patients should be offered the opportunity of a debrief when an incident of restraint has taken place. The reasons for the restraint should be clearly communicated and the patient should be given opportunity to raise any concerns or anxieties about their experience. It would be good practice to document these discussions. Where any concerns are raised by a patient, these should be discussed with the clinical team and individual care plans revised where appropriate.

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-in-mind/

Activity and occupation

As on previous visit, the occupational therapy (OT) department continue to offer a varied programme of activities for patients within the clinic, such as cooking groups, art groups and a variety of exercise based classes. Outwith the Orchard Clinic, on the Royal Edinburgh site, there are further activities offered at the Hive and the hospital gardens, run by the Cyrenians.

We heard consistent negative feedback from patients on this visit about a lack of activity provision on the ward itself. Patients who were more restricted to the ward environment spoke about being “bored” and said there was “not much to do”.

Staff agreed that this was a problem. A few members of the team had tried to make improvements, for example running a social group on the ward once a week, in addition to an informal music group and a karaoke night (for which a new machine had been purchased a

few weeks previously). However, there is no activity co-ordinator role on the ward, and staff shortages have meant that the ability to offer additional activities is limited. We felt this was an important aspect of patient care that warranted further resources, especially given the nature of the ward and the restrictions on the patient group.

Recommendation 2:
Managers should review activity provision on Redwood Ward and make steps to improve the availability of activity and meaningful occupation for patients within the ward environment. The appointment of an activity co-ordinator should be considered.

The physical environment

When we last visited the clinic, problems with the heating system had caused serious concern. Work had been undertaken since then to carry out repairs and staff advised us that there had been no further incidents. We welcomed plans for staff and managers to continue to monitor this over the winter and notify the Commission if any concerns arose. We learned from all the wards that, since our last visit, there had been cause to review security measures across the clinic. A significant programme of improvement work had since been completed to address this. We were told that a multidisciplinary Senior Management Working Group had subsequently been set up to continue to review the clinic environment. We welcomed this development.

The ward environment on Redwood was fairly busy and noisy on the day of our visit. We were told this was not unusual. The communal lounge and dining areas are situated around a central hub near the nursing office, and the chatter and circulation of patients and staff through this corridor and the surrounding spaces creates a constant background of noise and bustle. Although the potential for changing the environment is limited, adaptations such as the addition of noise-reduction panels could perhaps be considered. The addition of focused activities on the ward and the provision of more groups may also help. We were pleased to hear of plans to re-site the patients' payphone (currently outside the nursing office) to an interview room, in order to afford patients a quieter space and greater privacy to make calls.

One patient commented about the lack of privacy during visiting times. We were told that visits from family and friends are usually facilitated in the dining room. We asked senior staff about this. The current arrangements enable staff presence during visiting times, helping to ensure the safety of both patients and their visitors. It was acknowledged that this arrangement was not ideal, but if patients needed more privacy for certain visits, we were told that this could be arranged in other quieter rooms on the ward.

With regard to the general environment and upkeep of the ward, we felt that the decor looked rather tired. One glazed door panel in the patient lounge, overlooking the courtyard garden, was heavily stained, discoloured and unsightly. It gave the impression that this communal space was not cared for.

The fitness room on the ward also appeared neglected and a rather an uninviting space to use. We were advised that physiotherapy assessments can be made on referral and patients can be provided with individualised fitness programmes. We heard that a few patients used the room a lot. There was a cycling and rowing machine, which the staff had managed to

acquire from other hospital wards. The cross trainer had broken the previous week and we were told there were no funds to replace this. One patient commented to us that they did not get out for exercise. Given the issues of restriction and the importance of physical activity for patient wellbeing, resources should be provided to update, modernise and equip this space so that it is fit for purpose.

We viewed a few of the patient bedrooms. Again some of the furniture appeared rather tired and carpets and decor would benefit from upgrading. We were told that specific improvement work to patient bathrooms had been identified from recent environmental risk assessments, but that these improvements had not yet been carried out.

Patient bedrooms in Redwood Ward are arranged across three separate corridors, with a self-contained high dependency suite at the end of each corridor. These suites enable patients who require a period of intensive nursing support in a safe and contained environment to receive this enhanced care. In addition to a sleeping and lounge area, each suite offers a small enclosed outdoor space. We noted that there was no seating provided in these outdoor areas. All furnishings in the suites are fixed or immoveable, to ensure safety. One patient told us they would have welcomed the opportunity to sit outside when they were nursed in one of the suites. We discussed this with the senior charge nurse. We had seen a piece of moveable soft seating used in other secure environments, which we thought might be suitable for this purpose. We shared the details of another unit who had used this equipment and could offer advice if required.

We made a recommendation in our last report that the garden environment be reviewed. It was disappointing to see the outdoor courtyard still appearing rather desolate. We were told that volunteers had done some planting and that the estates department visited when requested to maintain the space. However, in comparison with other patient gardens on the hospital site, those available for patients at the Orchard Clinic remain of a poor standard.

Female Accommodation

In the past we have raised concerns about the lack of gender-sensitive accommodation in the Orchard Clinic, with lack of female designated areas in the two mixed wards.

In Redwood, one of the bedroom corridors is maintained as female-only where possible, which is welcomed. When we last visited the ward, a room that had been designated a female-only sitting room was not in use due to heating issues. We were pleased on this visit to hear that the problem had been rectified and the room was again in use.

One patient we spoke with welcomed the provision of this female-only space. We were concerned to hear that this individual did not feel able to use other communal areas on the ward, or to access the shared garden, due to feeling uncomfortable around male patients. The patient said they felt limited to either spending time in their bedroom or in the female sitting room and they would prefer to be in one of the high dependency suites so could access the outdoors and fresh air. We spoke with the senior charge nurse about ways to accommodate some of these requests.

We are aware that proposals have been made for some years to establish a female-only ward at the Orchard Clinic and it is disappointing that no progress has been made in realising these plans.

The Commission are 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.

Recommendation 3:
Where environmental risk assessments have identified significant safety concerns within the clinic environment, these should be carried out as soon as possible.

Recommendation 4:
Managers should address the environment concerns outlined in this report (including window panels, fitness room, outdoor areas and general decor on Redwood Ward), prioritise those requiring urgent attention, and develop an action plan to address these.

Recommendation 5:
The Senior Management Working Group reviewing the clinical environment, and developing future plans for medium secure care on the Royal Edinburgh Hospital site, should highlight ongoing concerns about the lack of provision for female patients with hospital managers.

Any other comments

The patients we spoke with raised a number of other general issues (such as food quality) that we recommended they took up with advocacy and raised at ward community meetings. One of these issues involved smoking and the ban on vaping in the clinic. Some patients were aware that vaping was permitted in another medium secure unit, as well as in prisons. The Commission considers that this is an issue for hospital managers. Senior staff advised us that the decision at the Royal Edinburgh is that vaping, like smoking, is not permitted anywhere within hospital grounds. We asked staff to explain this to patients. We confirmed that smoking cessation advice was offered to patients and nicotine replacement therapy was available. We heard that some nurse practitioners were also undergoing training to prescribe this.

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 where this is required.
2. Managers should review activity provision on Redwood Ward and make steps to improve the availability of activity and meaningful occupation for patients within the ward environment. The appointment of an activity co-ordinator should be considered.
3. Where environmental risk assessments have identified significant safety concerns within the clinic environment, these should be carried out as soon as possible.
4. Managers should address the environment concerns outlined in this report (including window panels, fitness room, outdoor areas and general decor on Redwood Ward), prioritise those requiring urgent attention, and develop an action plan to address these.
5. The Senior Management Working Group reviewing the clinical environment, and developing future plans for medium secure care on the Royal Edinburgh Hospital site, should highlight ongoing concerns about the lack of provision for female patients with hospital managers.

Good Practice

There were a few areas of good practice that we wished to highlight in this report.

Firstly, carer support, alongside patient advocacy, has been a strength across the Orchard Clinic for many years. Edinburgh Carers Council hold meetings with carers and staff on a routine basis and the senior charge nurse on Redwood and social workers in the clinic also organise carers support meetings. Although these have been running for many years, it was evident on hearing about the meetings how much thought is put into continuing to adapt them to meet the needs of carers. To maximise accessibility, trials such as changing the timing (daytime/evening) and days (weekdays/weekends) of the group had been attempted. Arrangements had also recently been made to hold the meetings at an alternative venue, independent of the hospital, to see if this suited carers better. Although we were told that attendance was sometimes poor, the team's commitment to continuing to engage with and support carers in this way was notable.

Secondly, we heard about a range of groups for staff across the clinic that are continuing to be developed. These included fortnightly "CAT chats" run by one of the psychologists and reflective practice groups, run by a nurse therapist. The latter are organised on a needs-led basis to support clinical teams in thinking about challenging cases. We were told of forthcoming plans for regular reflective groups to be run by a new member of staff. The aim for these groups, commencing in October, was to provide an opportunity for staff across the clinic - including those working in reception and administrative roles - to reflect on some of the challenges in their work and to share their experiences. We look forward to hearing how these groups continue to develop on future visits.

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@mwcscot.org.uk
website: www.mwcscot.org.uk