Mental Welfare Commission for Scotland

Report on unannounced visit to: Balcarres and Craiglockhart (adult acute admission wards), Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 17 September 2019

Where we visited

Balcarres and Craiglockhart wards are both 16-bedded adult acute admission wards with a catchment area that includes the north west and east areas of NHS Lothian. Balcarres admits only male patients; Craiglockhart is a female-only ward. We last visited these services in October 2018, and made recommendations about care planning and patients being informed of their rights and any restrictions placed upon them.

On the day of the visit we wanted to follow up on the previous recommendations and also look at the experience of patients who were receiving care at the time of our visit, specifically in relation to their involvement in the planning of this.

Who we met with

We met with and reviewed the care and treatment of 15 patients. Carers and relatives are usually advised, in advance, that we are visiting and that we would be available to meet with them. As this was an unannounced visit, no carers had been notified, and there were none who wished to meet with us at the time of our visit.

We also spoke with the clinical nurse manager, senior charge nurse, the charge nurse and members of the nursing team.

Commission visitors

Juliet Brock, Medical Officer

Moira Healy, Social Work Officer

Claire Lamza, Nursing Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Those that we met with on the day had a range of views about their inpatient experience. We heard from patients that they did have opportunities to discuss their care with nursing and medical staff. In Balcarres Ward, those that we spoke to said that they saw their doctor at least weekly, although in Craiglockhart Ward we were told that at times patients had to request to see their responsible medical officer. We were made aware that, due to changes in medical staff, there have been fewer psychiatrists available. However, this situation has improved recently.

We were told that, in general, nursing staff were supportive, approachable in terms of talking with patients about their care, treatment and mental health needs and, where possible, facilitating patients to have time off the ward. We heard that at times patients thought that there was a shortage of nurses. We were told that this created difficulties as some we spoke to told us that the wards could be "noisy, with people shouting all night". Patients also reported that communication between staff and patients could be problematic and that they occasionally felt unsafe.

We have noted in previous visit reports that both electronic and paper based patient records are in operation. We had been advised in 2017 that there were plans to move to a paper-light system, and would hope that this will be progressed in the near future. With both systems operating separately, we found there to be a lack of detail and cohesion between the paper-based care plans and the electronic record. We noted that in the paper-based care plan document, the setting out the patient's treatment goals were not linked or evaluated to the weekly ward round that was recorded on electronic system, TrakCare. We also found that in the section on the electronic record relating to risks, where there had been a review, this was not then updated on the paper-based version.

Recommendation 1:
Managers should develop a method whereby information in paper and electronic records is detailed and interrelated, until there is a single system defining a patient's care.

In our past reports, we had commented positively on the SCAMPER reviews. However, on this visit we found that the quality of the information in these has lessened. There was a lack of detail in relation to a patient's progress, with sections indicating that there was 'no change' or 'to continue with care plan'. We noted that the summaries of the weekly reviews via the SCAMPER system focused on the physical healthcare and the medication of the patient. While this in itself is positive, there was a lack of detail in terms of psychological/psychosocial interventions or therapeutic activity and engagement.

With the paper-based care plans, we noted that these also lacked detail. For some patients who had been in the wards for several weeks, we found a single care plan. Others that we reviewed lacked detail in terms of the interventions, were not personalised and did not evidence the involvement of the patient. We found different versions of a care plan template being used in both wards. When we discussed this on the day of our visit, we were informed that the acute wards are trialling a new format for care plans, and it is anticipated that the new

document will replace the previous version in the near future. We highlighted that there was a lack of space in the paper version for evaluation, or to identify progress.

Recommendation 2:
Managers should take a systematic approach to having a defined patient care plan that includes care goals which reflects the individualised needs of a patient, clearly notes changes over time, and defines the patient's involvement.

The Commission has produced good practice guidance on person-centred care plans which can be found at: https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

It is hoped that this can be used when actioning the above recommendations.

Use of mental health and incapacity legislation

On the day of our visit, most patients in both wards were detained under the Mental Health (Care and Treatment Act) (Scotland) 2003 ('the Mental Health Act). We found the forms relating to each patient's detention stored electronically on TrakCare, and, in some cases, copies were kept in the paper care files. Where required, the relevant forms for consent to treatment under the Act (T2) and forms authorising treatment (T3) were all in good order and available on both the electronic system and a copy kept with the medication prescription sheet.

On the day of our visit, there were no patients who required restrictions to be placed upon them under Sections 281-286 of the Mental Health Act. However, on reviewing patients' files, we noted that room searches were conducted in certain circumstances. We discussed the use of the specified person legislation with staff on the day of the visit and were advised that the relevant paperwork had been completed and filed, but we could find no record of this in either the paper or the electronic system. We addressed this with staff at the feedback session at the end of the day.

We noted that for those patients who were deemed to lack capacity to consent to their physical health treatment, we found appropriate use of the Adults with Incapacity (Scotland) 2000 Act, section 47 certificates and individual plans in place to authorise treatment.

Rights and restrictions

The door for access in and out of both wards is kept locked, and a member of staff is needed for anyone who wishes to enter/leave the ward. We noted that a member of staff was easily accessible to help with this. On the day of the visit, there was only one patient who was being cared for under an increased level of observation, and we found the documentation and need for observation to be appropriate for the patient's wellbeing.

In the files that we reviewed, we found the risk assessments to be of a good standard. Each patient has a clearly set out pass plan in their care file that indicates their time off ward, the level of risk, details of whether passes were escorted or unescorted, and the areas they were able to access. We did note that pass plans were also in place for those patients who were not formally detained. For those patients who did require to be escorted off ward, there was

evidence of this being supported by the activity co-ordinators, nursing and occupational therapy staff.

For those patients that requested input from advocacy and for legal representation, we found evidence of this in their care file. We also noted that the documentation in the file prompted staff to ask patients about advance statements and noted whether a patient had been informed of their rights. In some of the files that we reviewed, we found this section had not been completed. As we have noted this in previous reports, on the day of the visit we asked about the standard operating procedure (SOP) that was recently developed by NHS Lothian in relation to advance statements. This, along with the Commission's guidance, *Rights in Mind* would help staff in mental health services to 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/

Recommendation 3:
Managers should ensure that patients' rights are discussed and promoted and that this is clearly documented.

Activity and occupation

We heard about and found evidence of a range of activities that are available for patients in each ward. We were pleased to see that in Balcarres, there have been developments to the environment where a relaxation room and a games room are in the process of being completed. We noted that there was a weekly timetable and a community meeting for patients to engage in. In Craiglockhart, we heard about mindfulness and art groups, reading and social activities that are facilitated by the activity coordinator and the nursing assistants. Comments from those that we spoke to indicated that these members of the team are valued by patients. Unfortunately, both of these staff members were unavailable on the day of our visit, although other nursing and OT staff were continuing to offer some input in terms of activities for patients. In reviewing the patient's care files, we found in some notes that the evidence of the patient's activities was not clearly recorded.

Recommendation 4:
Managers should ensure that patient engagement in activities and occupation is clearly recorded in the care plan.

The physical environment

While there continues to be some positive improvements in the décor of the wards - we noted new murals painted in participation with patients and, therapy rooms decorated with artwork and individual recovery messages and images – there are areas where the décor needs refreshed, such as the main entrance to the wards, some corridor walls and patient rooms. We raised this on the day of the visit and were advised that there is a regular programme of works to review the décor. The staff members that we spoke to noted our comments and will action this with the relevant department in estates.

Some of the patients that we spoke with told us that access to the courtyard gardens and to tea/coffee making facilities can be restricted. We also heard that there is an issue with

smoking in Balcarres ward for patients who are unable to leave the ward. We noted that patients have been smoking in the bedroom area and in the courtyard and while staff are addressing this issue regularly, it continues to present problems for nurses and other patients who do not smoke. We discussed possible solutions at the feedback session at the end of the visit.

Recommendation 5:
Managers should ensure that there are actionable plans to deliver a no-smoking environment in their wards.

Any other comments

We were informed about an issue with the shortage of nursing staff as a result of other units opening across NHS Lothian's mental health services. We were advised that recruitment for additional staff is ongoing, but that in the short-term, this is likely to have an impact on the activities and interventions available for patients.

We also found that in one of the wards, there were a number of patients who met the diagnostic criteria for emotionally unstable personality disorder. We would suggest that the guidance from the Royal College of Psychiatrists (https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2018-college-reports/personality-disorder-in-scotland-raising-awareness-raising-expectations-raising-hope-cr214-aug-2018) and the themed report from the Mental Welfare Commission (https://www.mwcscot.org.uk/sites/default/files/2019-06/nov2018bpd_report_final.pdf) be reviewed, and consideration given to how the recommendations made in these reports could be implemented.

Summary of recommendations

1. Managers should develop a method whereby information in paper and electronic records is detailed and interrelated, until there is a single system defining a patient's care.

2. Managers should take a systematic approach to having a defined patient care plan that includes care goals that reflects the individualised needs of a patient, clearly notes changes over time and defines the patient's involvement.

3. Managers should ensure that patient's rights are discussed and promoted and that this is clearly documented.

4. Managers should ensure that patient engagement in activities and occupation is clearly recorded in the care plan.

5. Managers should ensure that there are actionable plans to deliver a no-smoking environment in their wards.

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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