Mental Welfare Commission for Scotland

Report on announced visit to: Meadows and Merchiston (adult acute admission) wards, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 6 November 2019

Where we visited

Meadows and Merchiston are both 16- bedded adult acute admission wards with a catchment area for the south west and south east areas of NHS Lothian. Meadows admits only female patients; Merchiston is a male- only ward. We last visited Meadows in September 2018, and Merchiston in January, 2019, and made recommendations about information completed in patient care plans, and what patients were told about in terms of their rights under the Mental Health (Care and Treatment)(Scotland) Act 2003 ('the Mental Health Act').

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 care plans and the advice they were given about their rights.

Who we met with

On the day of our visit, we met with, and reviewed the care and treatment of, 14 patients. We met and spoke with two carers: one prior to the visit; the other was present at the time of the visit. We also met with the clinical nurse manager, senior charge nurses, and members of the nursing team.

Commission visitors

Kate Fearnley, Executive Director (Engagement and Participation)

Philip Grieve, Nursing Officer

Paula John, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found

The patients and carers that we spoke to shared a range of views with us about the care and treatment that had been received during their inpatient stay. Patients told us that they felt listened to and that they could discuss their concerns and difficulties with the nursing and medical staff involved in their care. The carers we spoke with also advised us that they had been able to raise any concerns they had with the nursing team and medical staff involved in their relatives' care. They spoke to us about the need for their relatives to have more information about what was available for them, and about the plans that were in place to support them in their recovery.

Some patients discussed the experience of their admission. We heard that the impact of a lack of available beds at the time of admission had caused distress, as some patients had initially being cared for in unfamiliar environments. Others described a more positive experience, as they felt that with their current admission, in contrast to a previous one, that having their own room, and a ward team that was familiar to them, was more helpful for them.

We heard that for some, they were given information about what supports they could access, but others indicated that this information was not readily available and that they had to find out themselves. A suggestion that we heard was patients would find it helpful if there were more frequent follow-up meetings scheduled during the first week of their admission. We discussed this with staff on the day of the visit and were provided with a copy of the information leaflet available for patients, although it was unclear how often this was provided for patients, if they had understood the leaflet, and if it was reviewed with them during their admission.

Recommendation 1:

Managers should develop a system to record when the patient has been provided with information about what is available for them in terms of their care and treatment.

Care, treatment, support and participation

Both electronic and paper-based patient records are in operation, although there are plans to move to electronic patient records, which we understand is currently being progressed. With both systems in place, we found that there was a disconnect between the two, most notably with the care plans. This increases the risk of information potentially being missed or overlooked, which was evident in some of the paper-based risk assessment documentation, with no corresponding review completed in the electronic record.

Recommendation 2:

Managers should ensure that the provision of a single system for patient information be progressed.

In the paper-based files, we found that for those patients that we reviewed, some of the care plans were brief, that the quality and content of care plans varied, and there was limited evidence of a person-centred approached. We noted that some interventions and goals may not have been achievable given the patient's clinical presentation and, although there were defined review dates, there was limited information about what changes had been observed.

In the electronic records, we did find evidence of regular one to one discussions with nursing staff, although these were not always defined in this way. We would suggested that a heading be used to identify when this takes place. We also found that there were detailed updates from the multidisciplinary team (MDT) meeting, which provided a comprehensive overview of ongoing engagement from the different professional disciplines involved in the patient's care.

A previous recommendation on the electronic recording of MDT meeting/ward round using SCAMPER (which captures clinical team discussions and actions) had indicated that the sections on this format were not consistently completed. Unfortunately, we noted that this continues to be an issue, with some sections having no information recorded, or any indication that it had been reviewed. A further difficulty from the SCAMPER reviews were that it was not always possible to see whether actions identified at the weekly review were followed up in the subsequent week(s).

Recommendation 3:
Managers should put in place an audit system that reviews the information documented in the care plans and on SCAMPER.

We are aware that there is ongoing work to review the care plans and that the Commission's good practice guidance is integral to this. Our 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

Use of mental health and incapacity legislation

On the day of our visit, for those patients that we reviewed who were detained under the Mental Health Act, we found the forms relating to each patient's detention stored electronically on TrakCare. We were advised that a copy of the legislative paperwork is kept in the paper record for the patient, but this was not the case in all of the files that we reviewed. The implementation of a single system would help with this issue.

Where required, the relevant forms for consent to treatment under the Act (T2) and forms authorising treatment (T3) were available. There was one issue with an unsigned T2 form, and this was discussed with the staff at the time.

Where a patient lacks capacity in relation to decisions about other medical treatments, a certificate completed under a section 47 of the Adults with Incapacity (Scotland) Act 2000 legislation must be completed by a doctor. We found that this had been done appropriately, although an issue arose from a previous assessment of the patient's capacity, on a different healthcare condition. We considered that a review of possible treatments in relation to this illness should be undertaken by medical staff, and raised this with the senior charge nurse.

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.

Rights and restrictions

Access in and out of both wards is kept locked, although a member of staff is available for anyone who wishes to enter/leave the ward.

On the day of the visit, an increased level of observation was being used in one of the wards. Following on from a review of the care and fuller discussion with the nursing staff, we found that all of the interventions and strategies that had been considered and put in place to support patient safety. There was good evidence of physical healthcare assessments and regular reviews by the medical staff.

However, with the restrictions that were in place to manage the situation, we considered that seclusion was being used, but not documented and managed according to NHS Lothian's Seclusion policy, or the Commission's recently published guidance on seclusion which can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf

Recommendation 4:

Managers should ensure that all staff are aware of the policies and procedures in relation to the use of seclusion and risk assessment, and that the relevant guidance is followed.

We reviewed the risk assessments for all patients and found these in the paper-based care files. We noted that where a patient had been transferred from another ward, such as the intensive psychiatric care unit (IPCU), the risk assessment did not fully reflect the changes that would be associated with this. There was also a lack of reviews within defined timescales on the paper document, and in the electronic record, no updated information.

We found evidence of input from advocacy and for legal representation in patients care files, where this had been requested. There is a documentation in the patent files that prompted staff to ask patients about advance statements and noted whether a patient had been informed of their rights. For those patients who were detained under the Mental Health Act, we noted that they had been made aware of their rights, but for those patients who were informal, there was no indication that they had been similarly advised.

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

Activity and occupation

The range of activities available for patients in each ward was variable. In both wards, we found input from the ward based activity coordinators, and involvement with occupational therapy (OT). While the OT involvement was defined in the electronic record, engagement with the activity co-ordinators was not recorded to the same extent.

In Merchiston Ward, we found evidence of patients being able to access on and off ward activities. These included sessions with the open music therapy group, artlink, the reading

group, “getting to know me”, and the spiritual care service. Off ward activities ranged from attending local events such as the fireworks display, Morningside Library, as well as patients being supported with the transition back to their own home environment. In Meadows Ward, there was an activity taking place on the day of the visit, but we heard that activities such as this were not available as often as patients would like. We found the activity timetables to be limited in terms of what was on offer and, where there were opportunities for patients to create a therapeutic timetable for themselves, this had not been progressed.

Recommendation 5:
Managers should ensure that there are opportunities for patients to engage in devising and participating in activities, which are then clearly recorded in the care plan.

The physical environment

While there continues to be positive improvements in the decor of the ward, there is a painted mural of a discharge tree at the entrance of Meadows Ward which creates a positive impact in a key area of the ward. There are areas of both wards that would benefit from further development, with furnishing and fittings that would reduce the clinical feel of both units. This could then provide more diverse spaces that patients can access. Areas such as the enclosed courtyard, which remains open throughout the day and which patients have easy access to, could be improved with raised beds and would create an area for patients to engage in horticultural therapy. Another example would be the quiet room in Meadows Ward, which could be enhanced to maximise patients’ use.

There is also a lack of identified private areas for meeting patients out with their bedrooms and, as recommended in a previous visit, improvements could be made to one of the meeting rooms in Meadows Ward, which would make it safe for patient use.

As was the case with another adult acute inpatient ward that we recently visited, we were aware there is an issue with smoking in Merchiston Ward. We noted that patients have been smoking in the courtyard garden and in their bedrooms. Staff have been attempting to address this issue regularly, but told us that policies and process are not clear and consistently applied.

Recommendation 6:
Managers should ensure that there are actionable plans to create a therapeutic, smoke-free environment in both wards.

Any other comments

We found, and were advised that, the phone interpretation service available for those patients whose first language was not English was particularly appreciated. We were advised that it affords individuals more privacy and enables them to talk about issues which are difficult to discuss in the presence of people from their own community. We also found the creative with use of Google Translate supported additional communication.

Similar to the other female-only adult acute admission ward for NHS Lothian, we noted that 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 for those female patients, who meet this diagnostic criteria, and are admitted to mental health adult acute admission units.

Summary of recommendations

1. Managers should develop a system to record when the patient has been provided with information about what is available for them in terms of their care and treatment.
2. Managers should ensure that the provision of a single system for patient information be progressed.
3. Managers should put in place an audit system that reviews the information documented in the care plans and on SCAMPER.
4. Managers should ensure that all staff are aware of the policies and procedures in relation to the use of seclusion and risk assessment, and that the relevant guidance is followed.
5. Managers should ensure that there are opportunities for patients to engage in devising and participating in activities, which are then clearly recorded in the care plan.
6. Managers should ensure that there are actionable plans to create a therapeutic, smoke-free environment in both 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 Health 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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