Mental Welfare Commission for Scotland

Report on announced visit to: Adult sub-acute admission unit, Ward 13, Royal Edinburgh Hospital, Morningside Place, Edinburgh EH10 5HF

Date of visit: 15 January 2020

Where we visited

Ward 13 is a nine bedded unit, developed for patients who no longer require the level of care provided from adult acute in-patient care, but who still have ongoing treatment needs from an in-patient facility. This sub-acute service also provides an intermediate option for patients who are awaiting placement in other services such as rehabilitation or longer stay facilities based in the local community.

The ward is located in MacKinnon House, one of the main buildings in the Royal Edinburgh Hospital (REH); it has been renovated and updated to accommodate male and female patients who are transferred to the service from adult acute admission wards.

Who we met with

On the day of our visit, we met with and reviewed the care and treatment of eight patients, as well as meeting with three carers. We also spoke to the senior charge nurse (SCN), the charge nurse, members of the nursing team and the clinical nurse manager (CNM).

Commission visitors

Juliet Brock, Medical Officer

Claire Lamza, Nursing Officer

What people told us and what we found

The patients and carers that we spoke to discussed various aspects, in respect of the changes with their care since moving to ward 13. We heard from patients that they found there to be fewer staff available who were able to respond to them; some told us they were unhappy being in the ward as there were fewer activities, and staff were not as helpful and engaged as they would have wished.

We heard that patient care would not be disrupted as a result of the move but this was not their experience. Some carers/patients were concerned that access to different professional disciplines had reduced, as had the option to attend different activities. We heard that they thought the nursing team were trying their best, but expressed their disappointment to us about the role and remit of the ward.

We spoke to the senior charge nurse (SCN) who explained that the ward had been opened as a temporary measure, to help with bed management issues across the adult acute admission wards. However, there has been a recent agreement that ward 13 will remain open permanently. The SCN advised us that medical input is provided by a locum psychiatrist, that there are vacancies with the nursing team and input from other disciplines such as occupational therapy, physiotherapy and pharmacy is either reduced or not in place at this time. The pathway for patients transitioning to ward 13 has not, as yet, been incorporated into the acute in-patient services and the criteria for admission is still to be finalised.

We did acknowledge that the service had been operating as a temporary option for patients who no longer required acute care but with the agreement to open the ward permanently, the admission criteria, function and purpose for the unit cannot be defined. We recognise that investment in staffing and services for the ward will need to be put in place as soon as possible.

Recommendation 1:

Managers should provide a full multidisciplinary service that meets the needs of patients admitted to ward 13.

Care, treatment, support and participation

As with all wards in adult mental health services in the Royal Edinburgh Hospital, patient records are in a paper version as well as there being an electronic record on TrakCare, containing patient information.

In the paper based files, we found various documents. Some, like the risk assessments and care plans, were completed by the previous ward that the patient had been admitted too. The files also contained hard copies of documents in relation to the patient's legal status, where applicable. We found that where required, updates and reviews had been undertaken since the patient's move to ward 13.

In the electronic records, the daily progress recordings for all patients were detailed and gave a comprehensive overview of the clinical presentation and the input from the nursing team.

We found evidence of regular one to one sessions with keyworkers, other nursing staff and members of the clinical team.

We were pleased to see the developments in the care planning process. Where there was an active care goal, the problem/need was defined concisely, with a clear indication of what the desired outcome was to be. There was a timescale in terms of reviewing, what action was required that involved the patient, whether the goal had been achieved and the date of completion. We found the electronic approach to care planning to be more current and reflective of the actual focus of care. We could also see where goals had been updated or discontinued.

For some patients, there was ongoing contact from their previous clinical team members. In those instances, the use of reviews was evident; for patients who had transferred to the medical team for ward 13, we found that the mental state reviews were not as thorough. We also found that for some patients, the care goals were not reflected in the weekly multidisciplinary reviews, which uses SCAMPER.

Recommendation 2:

Managers should ensure that reviews incorporate the defined care goals, which should then be evaluated.

We are aware that there is ongoing work in relation to care plans and that the Commission's good practice guidance on person-centred care plans has been used to support this. This 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 who were detained under the Mental Health (Care and Treatment Act) (Scotland) 2003 (MHA), we found the forms relating to each patient's detention stored electronically on TrakCare. There was also a paper copy kept in the patient's care file.

There were no issues with forms for consent to treatment under the Act (T2), however where the form authorising a patient's treatment (T3) was required, we found one issue where there was no form in place, and the patient was being treated outwith the MHA. This was addressed on the day of the visit.

Where a patient lacks capacity in relation to decisions about other medical treatments, a certificate completed under a s47 of the Adults with Incapacity (Scotland) 2000 (AWI) legislation must be completed by a doctor. We found certificates, but there were no accompanying treatment plans. There was a further issue where we were unable to locate a copy of a power of attorney document and again we raised this at the time.

Recommendation 3:

Managers should ensure that all relevant documentation is in place so that treatment is legally authorised.

On the day of our visit, there were no patients who required restrictions to be placed upon them under s281-286 of the MHA.

Rights and restrictions

Access in and out of the ward is via a locked door, with no visual panel. Members of staff make themselves available for anyone who wishes to enter/leave the ward.

In the paper care file, there are documents that note if a patient has indicated that they have understood and been informed of their rights, if they have an advance statement and what time off the ward has been agreed. While the pass plans for time off ward were up to date and reflected any associated risks, the other information about rights and advance statements was not always completed; it also had not been updated since the patient had moved to ward 13. At the point where a patient is transferred, we would suggest that there is a further discussion about the patient's rights and making an advance statement, and that this is updated in their care file. We suggest that staff use the Commission's guidance, *Rights in Mind* which would provide advice for informal and formal patient in mental health services, to ensure that all 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/

Where requested, we noted that patients had access to advocacy and legal representation and this was documented in both paper and electronic notes.

All patients had a risk assessment in the paper-based care files. We found that while the assessment had been completed by the previous ward, an updated review had taken place during their time in ward 13.

Activity and occupation

On the day of our visit, staff had organised a coffee morning and there was an activity planner in the main day area. We heard that the different services such as art and music therapy have either began to have input to the ward, or are scheduled to.

We found that there were variable opportunities for patients to engage in a range of activities. For those who had established activity programmes prior to transfer, the majority of these continued to be supported when they had moved to the ward. However, we were advised that for some, there have been difficulties in providing input from specific disciplines, which would offer different activities and occupational opportunities for patients. We also were aware that for others, there were limited options in terms of on or off ward activities.

Recommendation 4:

Managers should ensure that the full range of activities and occupational activities are made available to all patients in ward 13.

The physical environment

Ward 13 has undergone renovations in order to meet the needs of the current patient group. The ward is freshly decorated, although it is one of the original wards based in an older building of REH. The majority of the rooms are small in size, and the doors have no privacy windows to assist with observation. At the time of our visit, there were only male patients in the ward, although bathrooms and toilets were being modified to accommodate female patients. We heard that adaptions have been made to ensure that there is a separate dining room for patients; this room is also used for meetings and visits.

There is one communal day area, a kitchen, outside space and a garden, should patients want to access these areas. Patients have their own room, although these are not en-suite; some patients had ample storage for their personal items, but for others, this was an issue and their personal belongings were not able to be stored safely. We discussed this with SCN and the CNM at the end of the visit and suggested that additional storage options be considered.

Any other comments

We are aware that that confirmation of ward 13 remaining open has just been given. We recognise that having a dedicated multidisciplinary team in place may not have been the original aim but, anticipate that on future visits, patients will receive the same care in this ward as they would in other REH wards.

We anticipate that the role and remit of the ward will have been finalised and the referral and treatment ethos will be in place in the near future.

Summary of recommendations

1. Managers should provide a full multi-disciplinary service that meets the identified criteria for patients admitted to ward 13.

2. Managers should ensure that reviews incorporate the defined care goals, which should then be evaluated.

3. Managers should ensure that all relevant documentation is in place so that treatment is legally authorised.

4. Managers should ensure that the full range of activities and occupational activities are made available to all patients in ward 13.

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

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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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