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: 28 & 29 June 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face-to-face visits; however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out as a combined face-to-face and virtual visit.

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

We last visited the rehabilitation wards at the Orchard Clinic in 2019 and made recommendations for managers to carry our regular audits on properly authorising patient medication and continued development of activities on Hawthorn Ward.

The Commission maintained regular contact with senior staff at the clinic from the onset of the pandemic. There was a clear strategic approach taken to reduce the risk of infection in the clinic and the wards remained free of Covid-19 throughout both first and second waves. We were encouraged to hear from senior staff how well patients had coped with increased restrictions throughout the pandemic. However through our contact with relatives, we heard how difficult this time had been, particularly with reduced hospital visiting.

On this visit we wanted to follow up on the previous recommendations and also look at people's experience of increased restrictions during the pandemic; particularly in relation to any reduction in activities and contact with families.

The visit was carried out over two days, to reduce the risk of infection between wards. On both days one commission visitor attended in person and the other joined remotely, meeting with patients and staff using Near Me technology.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and spoke with one relative.

We spoke with senior charge nurses (SCNs), members of the nursing team, the peer support worker, members of the occupational therapy (OT) and social work teams, and one of the consultant psychiatrists. In addition we liaised with Advocard, the hospital advocacy service.

Commission visitors

Juliet Brock, Medical Officer

Graham Morgan, Engagement and Participation Officer (lived experience)

What people told us and what we found

Care, treatment, support and participation

Both wards were full at the time of our visit. The patients we spoke with were generally very positive about the care and support they were receiving. They emphasised the focus on rehabilitation, in spite of difficulties during the pandemic. Comments shared with us included "the staff are keen to get you to do things"; "staff are so helpful… they go the extra yard" and "the charge nurse always asks how you are."

As on previous visits, staff were observed to be caring and respectful towards patients. It was evident from discussions on both wards that the staff were knowledgeable and thoughtful about the patients in their care and were striving to deliver rehabilitation and support to meet each person's individual needs.

The team continue to have input from a peer support worker and again, both patients and staff spoke very positively about this support.

We heard from patients, nursing staff, the peer support worker, OT and social worker how challenging the pandemic had been for the patient group. The impact of lockdowns had been particularly difficult, with patients largely confined to their wards, often spending long periods isolated in their rooms with a lack of access to activities. Understandably, for those patients who had previously had full day passes for community activities, those individuals struggled with the change to two 30 minute passes in the hospital grounds. Boredom and frustration were common and we heard that a few individuals experienced deterioration in their mental health during this time. However, the majority of patients had coped remarkably well. We were told there had not been significant escalation in anger or behavioural disturbance on the wards and that patients had coped well with staff support. Patients themselves told us they appreciated that they had been kept safe; one patient said "I'm getting benefit here as I am not exposed to Covid-19 in the community".

In the weeks before our visit, national restrictions had eased and patients were able to spend more time out of the clinic, hospital grounds and to engage more in community activities as these opened up.

Patient records

Information on patient files was held primarily on TrakCare, the electronic record system in used across NHS Lothian. A few documents were incompatible with electronic records and were stored separately on paper files. Electronic prescribing had also been recently introduced in the clinic and staff were getting used to using the online HEPMA (Hospital Electronic Prescribing and Medicines Administration) system for this.

When we last visited in September 2019, the wards across the clinic had just 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. In the

files we reviewed, the quality of care planning was variable. We suggest further improvement work is undertaken in this area.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We saw good evidence of multidisciplinary team (MDT) input in patient files, and care programme approach (CPA) records provided a high level of detail.

Recommendation 1:

Managers should arrange for the regular auditing of nursing care plans and introduce further improvement work to support staff development in this area.

Multidisciplinary working

We were told that during the pandemic many multidisciplinary team (MDT) meetings took place virtually, or were held on the ward in a limited capacity to enable safe social distancing.

Each team has input from occupational therapy and psychology, along with the involvement of art and music therapists, who are also available in the clinic. There is a full time clinical pharmacist now attached to the service, who we were told attends MDT meetings. Input from other professionals such as dietetics and physiotherapy is available on referral.

During the pandemic, consultant allocation had changed so that one consultant psychiatrist was responsible for each ward. We were advised this was to reduce the number of meetings and clinical contacts for each patient group. On Hawthorn Ward, there had been a number of changes in consultant cover (including locums) over a fifteen month period and we were told that some patients had been under the care of three or four different doctors during this time. A number of patients told us this had been difficult and the peer support worker also raised this as a concern that had been shared with them. Patients had experienced the changes as disruptive and an additional stress. One patient told us about a number of changes in their consultant and had found this discontinuity of care very difficult.

We were informed on this visit that consultant responsibility was about to revert to previous arrangements.

Use of mental health and incapacity legislation

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

With the move to electronic prescribing, it was not as straightforward to cross check the authority to treat for individual patients. Consent to treatment forms (T2) and certificates authorising treatment (T3) are not held on HEPMA and paper copies were not generally held on file in the treatment rooms, as they had been previously. We were however able to review prescribing with the T2/T3s for all patients on both wards, and found a concerning number of cases where medication was being given without the required legal authority in place.

In some cases new medications -not authorised in the patient's existing T2/T3- had been commenced without changes to the T2/T3 being sought. In a few cases patient's T3 certificates had expired. These failings were a serious concern, particularly as this issue was highlighted during the last visit and the Commission subsequently recommended that 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".

We discussed these concerns with senior staff on the day and were assured the errors would be rectified. We recommended that patients should be advised if they had been treated out with the Act and reminded of their right to advocacy and legal advice.

Recommendation 2:

Responsible Medical Officers (RMOs) should ensure that all medication for mental disorder prescribed for patients under their care is authorised in accordance with the Mental Health Act.

Recommendation 3:

As in our previous recommendation, managers should, as a matter of priority, establish a system of regular audit to ensure that every patient's prescribed medication is properly legally authorised.

Rights and restrictions

Patients have been subject to an increased level of restriction during the pandemic and we heard from patients and staff that this had been particularly difficult during both lockdowns.

Some patients and a few staff felt that that the stringent approach to reducing the risk of Covid-19 transmission in the clinic had led to unreasonable levels of restriction at times. Concerns particularly surrounded access to activities, the physical restriction of patients to their room/ward/the clinic perimeter at times and restrictions on family visits.

The recent easement of restrictions has been welcomed. However, in a number of areas it was still felt that there was a lack of parity between restrictions in hospital and for the wider public. This was raised particularly in relation to visiting arrangements.

Concerns about visiting (e.g. having only one nominated visitor per patient, visiting being restricted to a few booked sessions per week and meeting family in the hospital grounds not being permitted) had also been raised with the Commission separately by a number of families over previous months. The rules governing visiting on the Royal Edinburgh Hospital

site during Covid-19 has been informed by NHS Lothian policy, which in turn has been based on the regularly updated guidance from the Scottish Government for the NHS. It was the view of some of those we spoke with (both patients, carers and staff) that the health board was rather slow to adapt its policy and rules on visiting. Concern was also voiced that local guidance appeared primarily aimed at those receiving acute inpatient care, rather than patients in longer term hospital care settings. This discrepancy was more evident when the easing of visiting rules in care homes was not mirrored by that in long stay inpatient units. All patients on the wards had received both vaccines, as had many family members wishing to visit. We heard from a range of those that we spoke with that they felt that visiting restrictions remained unfair.

We asked that managers clarify the latest situation with NHS Lothian and senior managers in the hospital and advise the Commission if there were ongoing concerns for patient/carer rights in this regard.

Individual patients spoke of the support they had received from advocacy, including progressing complaints when they had concerns. We heard from advocacy about their concerns, in that it had been difficult to provide a service to patients at times, due to restrictions on professionals visiting the unit. We were told of instances where advocacy workers had been turned away at reception after visits had been arranged and agreed with ward staff. We shared these concerns with managers, who agreed to liaise with the advocacy service about improving communication and access in the future.

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

Overall, whilst it was felt by those we spoke with that restrictions imposed in the clinic during the earlier stages in the pandemic had largely been justified and provided benefit, it was important that these were reviewed in line with overall reductions in Covid-19 risk, to ensure a better balance for patients and their wellbeing.

Activity and occupation

Activity provision had been severely impacted during the pandemic. We heard from both patients and staff about the challenges this had brought. Group activities that would normally have been available for patients across the clinic had been significantly reduced or ceased while physical separation was maintained between wards. The decision to limit allied healthcare staff from working across more than one ward at any time (and at some points seeing only one patient a day) had also reduced the capacity for OT's and other therapists to provide input to patients across the clinic.

Creative solutions had been put in place to try to mitigate these difficulties. During the first lockdown, OTs produced individual activity packs for every patient in the clinic. There had also

been creative use of shared spaces, for example when the gym hall could not be used for group sports, the space was transformed to run art groups for each ward.

When easing of restrictions enabled small group sessions to recommence, badminton and yoga classes were set up, including weekly You-Tube yoga sessions. We were made aware, from both individual patients and from written feedback shared with us, about the positive impact these changes had. In Cypress unit, specifically set up to provide OT and therapy facilities, patients were able to book fitness sessions in the small gym, with access to running, cycling and rowing machines equipment. The newly refurbished OT kitchen also provided space for small group cooking and was used during week days and weekends, when nursing staff provided supervised sessions. Art and music therapy was recommenced for small groups and new activities had also been established, including astronomy sessions and IT groups run by the technical instructor, who also helped facilitate patient video contact with their families.

Patients were able to help in the OT garden and a weekly choir, held in the outdoor OT sports court, had also been established. We heard that the choir sessions, open to all in the clinic, had proved popular and were much enjoyed by patients and staff alike.

Opportunities for activities outside the clinic were starting to open up at the time of this visit. In the hospital grounds, the Cyrenians Gardens and the Hive Centre were offering the opportunity to book sessions. Patients told us they welcomed this and we heard about volunteering opportunities in the community restarting. The staff were hopeful that activities would continue and that individual activity and rehabilitation programmes could soon return to nearer pre-pandemic levels.

The physical environment

We were pleased to see that the communal areas on both wards were bright, clean and in a good state of repair, with the décor freshly painted in many areas. On Cedar Ward we were advised that new furniture had been ordered, which was welcomed by patients who had commented on the furnishings being tired. The staff on both wards had also been painting and updating the ‘quiet’ rooms, to make them more comfortable and inviting spaces for patients to relax in.

We viewed individual patient bedrooms on both wards. The en-suite rooms were in a reasonable state of repair. We did note however that the taps in bathroom basins posed a potential ligature risk. Other shower and toilet fittings were in keeping with ‘anti-ligature’ fixings used in the newer wards of the hospital. We were advised that this issue had been noted and pursued for several years, as it had been acknowledged that these fittings needed to be replaced across all bedrooms in the clinic. We were told that hospital managers had agreed funding, but that the process had stalled at the procurement stage. This requires addressing as a matter of priority.

We noted that some of the shower curtains on Hawthorn Ward were heavily stained, despite regular cleaning in the hospital laundry. Some did not appear to be showerproof. We recommended to managers that these all be replaced, as they had recently been on Cedar.

In the outdoor area, shared by both wards, staff and patients had been maintaining the space and planting seeds and growing vegetables in the raised beds. We were told that the garden was well used, particularly during summer months. We were pleased to note that the sports court had been cleared following the Commission's last visit and we were told this had been regularly used for outdoor activities. However, we were advised that none of the outdoor courts in the clinic were safe for patient use at the time of the visit because of heavy moss growth. Attempts had been made to have the courts professionally cleaned, but it had not been possible to arrange this. We recommended that managers prioritise finding a solution, so that these spaces can again be utilised for outdoor sports by the patient group.

The garden could still benefit from further upgrading: the wooden seating appeared old and tired and the paintwork on wooden doors and windows in the courtyard was peeling and required attention. The standard of outdoor facilities in the Orchard Clinic remains generally lacking as compared to that available for patients in newer wards on the hospital site.

As outlined in previous reports, ongoing concerns have been raised by staff about the fabric of the Clinic, which is now 20 years old. Questions have been raised about how the current environment will continue to meet the needs of the patient group in the future. A Senior Management Working Group was previously set up to review the clinic environment. In addition to addressing maintenance issues, the group had planned to look at how medium secure care on the REH site might best be provided in the future. We were not updated of current progress or planning in this area. Recommendations recently made by the Independent Review of Forensic Services, commissioned by the Scottish Government, may influence national planning for forensic services going forward, particularly for women requiring medium secure care. A Government response to the recommendations has not been published at the time of writing this report.

Recommendation 4:

Hospital managers should urgently address the continued delays in upgrading bathroom fittings in patient bedrooms across the clinic to reduce potential environmental risks. Further action in relation to the internal and external fixtures and fitting should also be detailed in an action plan for this work, including timescales, and should be provided to the Commission.

Any other comments

At the time of this visit, the patient group on Hawthorn ward included two women, both of whom we met. No concerns were raised by patients or staff about the current gender mix on the ward or any issues arising from this. This is an area the Commission will continue to monitor on future visits, given the general acknowledgement for the need of single sex provision in medium secure care.

The Commission is aware of delays patients experience in moving between forensic services, primarily due to limited resources in national provision at the current time. On this visit, we were advised of a waiting list for rehabilitation admissions. The experiences shared by individual patients and staff was that discharges to lower secure settings had been also been further delayed during the pandemic. This was mainly due to the practical challenges of supporting transitions between services. We are aware this has been a difficulty across forensic services during Covid-19. We were encouraged to hear that successful discharges had however taken place and that several patients were in the process of transition to lower secure care at the time of this visit.

Summary of recommendations

1. Managers should arrange for the regular auditing of nursing care plans and introduce further improvement work to support staff development in this area.

2. Responsible Medical Officers (RMOs) should ensure that all medication for mental disorder prescribed for patients under their care is authorised in accordance with the Mental Health Act.

3. As in our previous recommendation, managers should, as a matter of priority, establish a system of regular audit to ensure that every patient's prescribed medication is properly legally authorised.

4. Hospital managers should urgently address the continued delays in upgrading bathroom fittings in patient bedrooms across the clinic to reduce potential environmental risks. Further action in relation to the internal and external fixtures and fitting should also be detailed in an action plan for this work, including timescales, and should be provided to the Commission.

Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving 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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