Mental Welfare Commission for Scotland

Report on announced visit to: Fairmile and Canaan wards, Royal Edinburgh Hospital, Morningside Terrace**,** Edinburgh EH10 5HF

Date of visit: 31 May 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 face-to-face.

Canaan and Fairmile are dementia assessment wards for older people in Edinburgh. The wards have been based in purpose built facilities in the new Royal Edinburgh Building since June 2017. Canaan is a male ward and Fairmile is female. Both have 15 beds and provide single en-suite facilities for every patient.

We last visited this service on 27 March 2018 and made only one recommendation, that managers should address the lack of lockable storage space in patients' bedrooms.

On this visits we wanted to follow up on the previous recommendation and also look at people's experience of increased restrictions, particularly in relation to reduced family contact, during the pandemic.

The Commission had maintained contact with senior managers throughout Covid-19, receiving regular updates on the status of the wards. In the early stages of the pandemic, the function of both wards changed; one was an admission ward for patients who tested positive for Covid-19, the other temporarily functioning as a mixed sex dementia ward. We were due to visit at the end of 2020, but postponed the visit due to increased pressures on the service and staff team as a result of the pandemic at the time.

Who we met with

We met with and or reviewed the care and treatment of six patients and spoke with two carers/ relatives/ friends.

We also spoke with the charge nurses and nursing staff on the wards.

Commission visitors

Dr Juliet Brock, Medical Officer

Anne Buchanan, Nursing Officer

Dr Sreedevi Alkanti, Higher Trainee on secondment

What people told us and what we found

Care, treatment, support and participation

At the time of our visit both wards were full.

The interactions we witnessed between staff and patients throughout the visit were warm, caring and respectful.

The patients we met with were happy with their care and raised no concerns or complaints. The carers we spoke with were complimentary about the care their relative was receiving and spoke of good communication from staff about aspects of their loved one's care and treatment. One described the care of their relative as "exceptional".

At the time of this visit Covid-19 restrictions meant that each patient had one nominated visitor. Visits could be arranged in advance on a booking system, with 30 minute slots available for each patient a few times a week. Visitors were required to wear PPE and visits were facilitated in a designated visiting room, which was cleaned after every visit. Senior staff advised that visits from family were also encouraged in the hospital grounds for those patients who were able to have time out of the ward.

Staff told us they facilitated planned phone calls with family members each week and carers were also encouraged to join discharge planning meetings via videoconferencing. The staff shared that a positive impact of the pandemic had been that the team were now much more proactive in maintaining communication with relatives.

Clinical Notes

Clinical notes are mainly held electronically on TrakCare, with a few documents (such as DNA CPR forms and anticipatory care plans) remaining in paper files.

We saw evidence of well-completed *Getting to Know Me* forms.

Care plans were generally of a good standard. Some patients had very detailed and comprehensive person-centred care plans, including the management of stress and distressed behaviours. Some were less detailed and lacked specificity in relation to the individual. We saw evidence that care plans were being reviewed regularly and suggest that this continues as the auditing of care plans would be beneficial to ensure consistency in the quality of these.

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 found that the daily progress notes sometimes lacked detail and meaningful content and in some cases and could have been improved. Consistent recording of patient participation in activities (or refusal to do so) would have been helpful.

Multidisciplinary working

We saw good evidence of multidisciplinary team (MDT) working on the wards, with a number of patients receiving support from a range of professionals including psychology, occupational therapy, speech and language therapy and physiotherapy. We were advised that a pharmacist attends the weekly MDT meeting for both wards, along with professionals from other disciplines.

We were advised by staff of a good level of psychology input, with clinical psychology involved in the development of formulations and behavioural support plans for individual patients, as well as supporting staff training, particularly in the management of stress and distress.

Recommendation 1:
Managers should review the quality of information recorded in daily entries to ensure this provides a meaningful narrative on individual patient's difficulties, progress and recovery. A regular audit programme of the care plan should be developed to ensure their quality.

Use of mental health and incapacity legislation

At the time of our visit, a number of patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Many patients had either power of attorney or guardianship in place under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

In general we found good documentation and record keeping across both wards in relation to the Mental Health Act and the AWI Act.

Medication is now prescribed electronically using the HEPMA (Hospital Electronic Prescribing and Medicines Administration) system. We reviewed online prescribing and manually cross-checked authorisation (on T2/T3 certificates) for patients receiving treatment under the MHA. We found some discrepancies, with a few patients receiving treatment which was not properly authorised. In one case a patient had been treated outwith the Mental Health Act for several months, with no T2/T3 in place. These issues were highlighted with senior staff on the day.

When patients required Section 47 consent to treatment certificates under the AWI Act, these appeared to have been completed.

Recommendation 2:

Responsible Medical Officers (RMOs) must ensure that all treatment given to patients under the Mental Health Act is properly authorised. Managers should carry out regular audits of prescribing and of T2/T3s to ensure that all prescribed treatment is legally authorised.

Rights and restrictions

Both wards have a locked door policy and information about this policy was displayed outside wards for visitors.

We had concerns about the restriction of access to clothing for male patients. This is discussed further in the environment section.

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

Both wards have full time activity coordinators. We heard from staff and saw evidence of the continued benefit of this role. The activity coordinators provide both one-to-one and small group activities to suit the needs of the patient group. The range of activities provided had been subject to limitations during the pandemic, with most of the patient group initially shielding, prior to the easing of restrictions and roll out of the vaccination programme. We were told during this visit however that the situation was improving, with patients able to get out more, for example minibus trips out with the hospital had been restarted for small groups.

We heard about input from outside organisations, including recent visits from the Scottish Chamber Orchestra. We were also pleased to hear about access to other activities in the hospital grounds, including the recent reopening of the Cyrenians' gardens, which patients had been able to visit.

On the day of our visit, we saw patients participating in a movement to music class in the morning and enjoying lunch outside in the sunshine of the ward garden.

The physical environment

As detailed in the last visit report, the environment in the new wards is light, bright and welcoming. The wards remain in good decorative order and are dementia friendly with clear signage.

In addition to the open plan communal lounge/dining areas, other rooms had been allocated for patients to freely use. These included a 'quiet room', which we were told was well used, and on Canaan Ward, the room formerly housing the dementia café had been converted to a 'pub', which the patients enjoyed spending time in.

The outdoor space was also inviting and well maintained, with several seating areas, handrails for those wishing to safely access this area and features of interest including raised beds and outdoor games (Connect 4 on Canaan Ward).

Bedrooms were clean and well kept. However, we were concerned again on this visit by wardrobe arrangements for patients on Canaan Ward. Men had no clothing kept in their room. All clothing items were held in a central storage room. We were advised that 'bundles' were brought to each patient in the morning to select their clothes for the day. Staff advised the reason for this was ongoing concern about ligature risks from wardrobe doors, which had been removed. This did not seem to be a concern on the female ward, where no such restrictions were in place. Senior nursing staff shared concerns about this practice, which we agreed infringed patient's rights and their ability to exert autonomy and independence over the simple daily task of choosing items of clothing. This was particularly concerning given the only recommendation from our last visit related to this same issue.

It was notable that in adjoining en-suite patient bathrooms, the taps presented an obvious ligature risk. We suggest that a detailed environmental audit is carried out across both wards, specifically looking at these risks, with a view to resolving current discrepancies. We suggest reviewing adult acute wards in the building to find out how any similar design issues have been addressed. A solution should be found to the wardrobe problem on Canaan.

Recommendation 3:

Senior managers should urgently carry out an environmental risk review of patient bedrooms and en-suite facilities. As a matter of priority, an appropriate solution must be found to enable patients on Canaan Ward to access their clothing in their room. The Commission expects to receive details of this solution.

Any other comments

At the time of this visit we noted that a number of patients with functional illness (some under 65) were receiving care on the dementia assessment wards due to pressure on beds in other parts of the inpatient mental health service.

We were also advised of a number of delayed discharges and heard that delays were primarily due to waiting for welfare guardianship applications to progress through court. Patients were usually referred to social work within a few weeks of admission, however we were told that sometimes social work did not become involved until the patient became a delayed discharge. We heard that a weekly 'delayed discharge hub' took place, with patients from across older people's services being discussed, to alert and help progress individual cases.

The Commission's recent Authority to Discharge Report provides further details of best practice in supporting people out of hospital. The report can be found here: https://www.mwcscot.org.uk/sites/default/files/2021-05/AuthorityToDischarge-Report_May2021.pdf

Summary of recommendations

1. Managers should review the quality of information recorded in daily entries to ensure this provides a meaningful narrative on individual patient's difficulties, progress and recovery. A regular audit programme of the care plan should be developed to ensure their quality.

2. Responsible Medical Officers (RMOs) must ensure that all treatment given to patients under the Mental Health Act is properly authorised. Managers should carry out regular audits of prescribing and of T2/T3s to ensure that all prescribed treatment is legally authorised.

3. Senior managers should urgently carry out an environmental risk review of patient bedrooms and en-suite facilities. As a matter of priority, an appropriate solution must be found to enable patients on Canaan Ward to access their clothing in their room. The Commission expects to receive details of this solution.

Good practice

We were told that when patients are admitted, information is sent to relatives about the ward. The feedback received by staff was that this had been particularly helpful during Covid-19 when family were unable to visit. Families were encouraged to complete *Getting to Know Me* forms during this early contact.

We noted that in Canaan ward, a noticeboard in each patient's bedroom had key information about them (e.g. background/ work/ interests, based on *Getting to Know Me*). This helped encourage reminiscence and prompted a person-centred approach when staff were offering daily support and personal care to each individual.

Service response to recommendations

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