Mental Welfare Commission for Scotland

Report on announced visit to: Craiglockhart Ward, Royal Edinburgh Hospital, Morningside Place, Edinburgh EH10 5HF

Date of visit: 24 March 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was able to be carried out face-to-face.

Craiglockhart is a 16-bedded female only adult acute admission ward with a catchment area that includes the northwest and east areas of NHS Lothian. We last visited this service on 17 September 2019 and made recommendations regarding the development of single system to record patient's care, care planning, the promotion of patient's rights, recording of activities in the patient's care plan and development of an action plan to support a no-smoking environment in the ward.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how patients and staff have managed throughout the current pandemic. In addition, we wanted to follow up the extent to which progress has been made towards the involvement of the patients in their care planning and the promotion of their rights.

Who we met with

We met with and reviewed the care and treatment of five patients during this visit.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), charge nurse, members of the nursing team, the activities co-ordinator and had contact with the art therapist.

Commission visitors

Kathleen Liddell, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found

Comments from the patients

The patients we met with on the day reported a range of views about their in-patient experience. Those we met with were able to identify staff members in the ward that they felt were supportive, approachable and offered them assistance when required. We heard that for some, being supported had helped to build confidence and engagement in a range of new activities.

We were also told by the patients that they were aware of staff shortages and felt their care would benefit from having more staff available to them, especially if they were visible around the ward. The patients did not always feel that they could approach staff when they were in the duty room as they told us they were concerned that they were causing an inconvenience for staff. Patients further commented that when staffing numbers were higher than usual, they said it would be beneficial to their care and treatment to have this level of staff more regularly.

There were some patients we spoke with who told us that they found the skill and age mix of nursing staff to be a barrier. For those patients, they explained that they felt approaching younger, newly qualified staff was difficult, and that the onus was on them to ask for support and help. We also heard that more contact from their Consultant Psychiatrist would be helpful and that they did not always feel involved in planning relating to their care, support and treatment.

All of the patients we spoke to were positive about the activities co-ordinator role, psychology and art therapy.

Care, treatment, support and participation

On the day of our visit, Craiglockhart Ward had 11 patients. Three of the beds had been transferred to the adjoining ward, Balcarres Ward, due to increased demands on male beds.

The ward was busy with some of the patients and staff engaging in activities in the communal area. The interactions we observed between staff and patients were responsive and positive.

The patients that we spoke with told us that communication between staff and patients could be problematic and they occasionally felt unsafe in the ward. We heard from the SCN that a 'Handover Safety Brief Standard Operating Procedure' (SOP) has been developed by NHS Lothian to support the transfer of high quality information at nursing shift change periods. We heard from some staff that further development of this is required to ensure clear communication at handover periods.

Care and treatment in the ward is provided by the multidisciplinary team (MDT); in this team are mental health nurses (MHN), two consultant psychiatrists and a junior doctor, and there is sessional input from psychology, an occupational therapist (OT), an art therapist and a full time activities co-ordinator. The OTs are not based in the ward and at present and there is a referral system in place to access OT intervention. We were told that this arrangement is being reviewed with the view to OTs being more ward based. The majority of the patients in the ward on the day of the visit had an allocated MHO.

We noted in previous reports that patients had limited access to psychology sessions. We were pleased to hear that there has been a recent increase in psychology input into the ward and that this has been beneficial to patients and staff. For patients, this service offers access to psychological therapies and for staff, the opportunity to develop formulations in patients care and treatment. Although this in its infancy, it is hoped psychology input will enhance the clinical skills and knowledge of the staff in supporting patients in Craiglockhart Ward.

On the day of the visit, we were advised of one patient who was a delayed discharge due to a lack of a suitable specialist community resources. We were pleased to note that social work were involved and attended the MDT meetings to plan for discharge.

Each consultant psychiatrist has a weekly ward round in which members of the MDT provide feedback to the clinical team outlining the patient's progress. The ward rounds are held in person on the ward. Patients do not attend the ward rounds and we heard that the outcomes of the ward rounds are fed back to patients via their named nurse. We suggest that offering patients an opportunity to attend these meetings will help support engagement, and give them an opportunity to meet with all members of the team.

We reviewed the electronic patient files. In the previous visit report both electronic and paper based patient records were in operation resulting in a lack of detail and cohesion between the paper-based care plans and the electronic records. We made a recommendation in 2019 that a single system defining the patient's care should be developed. We were pleased to find that all information is now recorded on TrakCare, the NHS Lothian electronic patient record system.

We have noted in previous reports that care plans lacked detail and were not personalised, person centred or focussed on recovery. While we found that some action had been taken with this recommendation, we observe that further work is required in terms of making the care plans more person-centred, recovery focused and should include evidence of patient participation.

All of the patients we met with during the visit told us that they had not been actively involved in their care plan, although some were unaware they had a care plan. The involvement of the patient in their treatment and care is an important principle underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). In some care plans, the section relating to outcomes blank. Although patient goals were recorded, there was no clear indication as to how these would be achieved and they were not easily identified as part of the decision making in the weekly ward round. The care plans we reviewed had gaps in relation to activity and occupation and did not regularly record patient or family/carer participation. There was a lack of recovery and strengths based content and identification of next stages in discharge planning. We found that some of the records that are completed on a shift by shift basis were repetitive, lacked detail and made it difficult to discern what the current issues were and what interventions had been put in place with patients. However we also noted that the daily progress notes recorded on TrakCare were of a good standard; they were goal and recovery focussed, detailing clear interventions and planning.

We heard from the CNM that there will be ongoing work to develop and improve care planning with a new system for auditing care plans that will soon be implemented to support quality assurance.

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

Recommendation 1:

Managers should ensure increased patient participation in care planning. Care plans should have evidence of goals and outcomes that can realistically meet the patients care and treatment needs.

Use of mental health and incapacity legislation

On the day of our visit, nine patients were detained under the Mental Health Act. We found the forms relating to each patient's detention stored electronically on TrakCare.

Only one of the patients we spoke to had an advanced statement in their file. We found that other patients had limited knowledge of what advanced statements are and therefore had not had the opportunity to make decisions and choices about their care and treatment. We discussed the health board's responsibility with the SCN in promoting advanced statements as a way of ensuring that people with mental ill health are listened to and their rights respected. We made suggestions as to how advanced statements can be promoted in the ward and the importance of recording the reasons if a patient declined an advanced statement.

The Commission has produced a range of guidance in relation to advance statements. These can be found at:

https://www.mwcscot.org.uk/law-and-rights/advance-statements

No patients required consent to treatment certificates at the time of the visit. An independent designated medical practitioner (DMP) visit had been requested for a patient whose treatment would soon need to be lawfully authorised under the Mental Health Act.

Where a patient may be subject to Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') legislation we would expect to find relevant paperwork in the patient's care file. Where a patient has been assessed to lack capacity in relation to decisions about medical treatment for physical healthcare, a certificate completed under Section 47 of the AWI Act must be completed by a doctor. All patients in the ward were able to consent to their physical health treatment.

Rights and restrictions

Access in and out of the ward is via a locked door and a member of staff is needed to facilitate access for anyone who wishes to enter or leave the ward. We noted that a member of staff was easily accessible to help with entering and exiting the ward.

On the day of the visit, there were no patients on increased levels of observation.

In the files we reviewed, we found risk assessments to be of a good standard. Each patient has a set pass plan which indicated time off the ward, the level of risk and details of whether passes were escorted or unescorted. On the day of the visit we found that for those patients whose care was informal, they were also assessed as requiring escorted passes by either staff or family. In discussion with the SCN, we heard that a senior psychiatric review of patients is undertaken as soon as possible after admission. We found that this was not reviewed in a timely way and we were concerned that in the case where a patient was voluntarily accepting care, escorted passes without a risk assessment to evidence the need for these was overly restrictive. We raised these concerns with the SCN and CNM on the day of the visit.

Sections 281-286 of the Mental Health Act provide a framework in which restrictions can be put in place, if required. The Commission would expect any restrictions to be legally authorised and the need for specific restrictions to be regularly reviewed. On the day of our visit there were no patients who required restrictions to be placed upon them under these sections of the Mental Health Act.

From the patients we met with, we found that they had a mixed understanding of their rights and we considered that more positive action could be taken to inform patients of their rights. We found in 2019 visit report that documentation had not been completed in relation to patient's being made aware of their rights and made a recommendation that patient's rights should be promoted and clearly documented. We were disappointed to note that there was no clear documentation of patients being aware of their rights. We raised this on the day of the visit, and offered advice on the ways a more rights based approach could be implemented to ensure patients are fully aware of their rights.

We were pleased to hear that the Patients Council in the Royal Edinburgh Hospital have funding to deliver human rights training to staff, although the timescale for this has yet to be confirmed. This training will help inform staff's understanding and knowledge about rights-based practice, benefitting patients experience in the ward; we look forward to hearing about this when we next visit the ward.

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

Recommendation 2:

Mangers should ensure that rights based care is delivered to patients and recorded in patient care plans. Managers should ensure that information on rights is visible throughout the ward.

We spoke with advocacy as part of the visit. We heard from patients and staff that advocacy support is easily available on the ward. Many of the patients we met with told us that they had advocacy involvement and viewed this as positive. We also heard that the Patient Council have started to attend the ward regularly and offer collective advocacy to patients.

From those that we spoke with, we heard that they were accessing legal representation as required.

Activity and occupation

We were pleased to hear about and to see evidence of a range of activities that are available for patients in the ward. However, some of the comments from those that we spoke to on the day of the visit told us that there are periods of time in the ward with no activity. Some described feeling 'bored and unmotivated', and felt that staff shortages meant that staff were not as available to support them to attend activities outwith the ward environment.

We heard from both staff and patients about how much they valued the dedicated space that had previously been available in the ward for engagement in recreational and therapeutic activities. This space has now been adapted as an additional bed area that is used when there are additional demand for beds. We were concerned to hear that this dedicated activity space has become a room for patients to use as a bed area; we discussed our concerns with the SCN and the CNM that this room was not fit for purpose as a bedroom, as it is lacking in appropriate facilities.

Without access to the well situated activity area, we heard about and observed that the activities such as relaxation and mindful colouring now have to be accommodated in the communal day area. Those that we heard from on the day of the visit told us that this area was not suitable for activities work as it was in a busy area of the ward, near the TV and courtyard. Patients told us that this area did not allow for the range of activities that had once been offered; nor did it feel like a therapeutic space. Some of the patients told us that if the area was too busy and loud, they would opt out of engaging in activities and go to their room.

Recommendation 3:

Managers should ensure that there is an appropriate and dedicated space in the ward for the purpose of activities.

It was positive to note that some of the patients have started to attend projects in the hospital grounds. We were also pleased to hear that art therapy is available in the ward. Those patients who access this spoke positively about the art therapist's input. We were able to discuss with the art therapist the impact of their role, and heard about the person-centred psychological therapy and how it is provided individually and group sessions; there is an emphasis on promoting the positive impact the arts can bring to a patient's mental health and wellbeing.

This supports close working with the MDT, the contribution to care planning, and aids ongoing assessment of an individual's care and treatment needs.

We were concerned that currently there are limited opportunities for patients to discuss any ward based issues with staff as the community meetings have been postponed since the start of the pandemic. The SCN advised that ward community meetings will be re-established to provide a forum for patients to voice their views and discuss issues.

The physical environment

We found that there are areas of the environment where the décor needs to be refreshed, most notably the interview room and courtyard. We noted that some of the furniture could benefit from an upgrade to offer a more welcoming and therapeutic environment. We raised this on the day and were advised that there is a regular programme of works to review décor.

We were told by CNM that that some of the doors in the ward required repair and a request had been made for this work to take place imminently. We were also told that there is a project to replace all room doors in NHS Lothian wards to offer a safer environment. Adult acute wards in Royal Edinburgh Hospital have been prioritised for this work.

In the previous report, patients told us that there was restricted access to the courtyard gardens and tea/coffee making facilities can be restricted. We were told that the kitchen is now open throughout the day and patients can freely use tea and coffee making facilities. The courtyard is open until midnight. We were told that the courtyard closing at midnight is to encourage sleep and minimise smoking at night.

We noted in the previous report that patients had been smoking in the bedroom areas and in the courtyard. We made a recommendation that plans to deliver a no-smoking environment in the ward should be developed. We noted that patients continue to smoke to in the courtyard area and occasionally in their rooms. We heard from staff that the restrictions imposed on patients from Covid-19 increased smoking in the ward environment. NHS Lothian sought advice from Public Health during the first Covi-19 lockdown to permit smoking in the courtyards, to prevent patients smoking in the ward environment due to the associated risks. During the visit, we witnessed patients regularly smoking in the courtyard. Staff we spoke to told us that it will be difficult to change the current smoking arrangement although we heard that plans are in place to support a no-smoking environment. A smoking cessation worker has recently been employed alongside a senior health promotion worker, to support a review all of NHS Lothian’s smoking policies and assist in their implementation.

Any other comments

We heard from the SCN about plans for additional training for nursing staff that will enhance their skills. Training in relation to trauma informed practice and working with challenging patients will support nursing staff to ensure patients are provided with care that offers safety and stabilisation.

From the staff we spoke to, we heard about some of the difficulties while working through the COVID-19 pandemic. We were impressed to see and hear about the ways staff have continued to provide a quality service despite numerous challenges, including staff shortages.

Summary of recommendations

1. Managers should ensure increased patient participation in care planning. Care plans should have evidence of goals and outcomes that can realistically meet the patients care and treatment needs.

2. Mangers should ensure that rights based care is delivered to patients and recorded in patient care plans. Managers should ensure that information on rights is visible throughout the ward.

3. Managers should consider returning the dedicated space in the ward for the purpose of activities.

Good practice

We were pleased to hear from senior managers that there is a carers group covering acute admission wards. This group is run in partnership with Vocal, Edinburgh Carers Hub, and facilitated by SCNs, and OTs from Royal Edinburgh and Associated Services (REAS). The feedback has been very positive with the aim that carers feel fully supported and involved in care planning.

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.

Suzanne McGuinness
Executive Director (Social Work)

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 Commission 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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