Mental Welfare Commission for Scotland

Report on announced visit to: The William Fraser Centre, Royal Edinburgh Hospital, Edinburgh EH10 5HF

Date of visit: 9 June 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.

The William Fraser Centre is part of NHS Lothian's learning disability service, located in the grounds of the Royal Edinburgh Hospital. The William Fraser Centre is divided into three areas with a total of 12 beds. Strathaird is a five-bedded, male-only unit. Culzean is a three bedded female unit, and Rannochmor has four beds, also for female patients. The centre acts as the main admission service for all patients with learning disabilities across NHS Lothian. It admits patients with a mild to moderate learning disability, who may have additional difficulties such as mental ill health, forensic needs, autism, and/or challenging behaviour.

We last visited this service on 28 November 2018 and made recommendations regarding reviewing the process for developing treatment goals.

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 pandemic.

Who we met with

We met with and or reviewed the care and treatment of eight patients. No relatives wanted to speak or meet with us. We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), one of the lead nurses and one of the consultant psychiatrists.

Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Comments from the patients

The patients we met with on the day of the visit told us that they were happy with their care and treatment in the William Fraser Centre. One patient commented that they "felt safe and listened to" with another patient telling us that staff were "kind and supportive".

Patients told us that there is consistency in the staffing on each of the units in the William Fraser Centre. The patients we spoke to viewed this as positive as it supported therapeutic relationships with staff and consistency in care. The patients we met told us that they have regular contact with their named nurse and this was evidenced on review of the patients' files. We were told by patients that they usually see their consultant psychiatrist weekly. Most patients we met said they felt involved in decision-making about their care.

Some of the patients we met with told us that they felt their admission to the William Fraser Centre had been for too long a period of time and were unclear about discharge planning. On the day of our visit, there were two delayed discharge patients in the William Fraser Centre. We were advised that the lack of a suitable specialist resource in the community was the cause of the delay. We highlighted a lack of discussion around discharge planning in the multidisciplinary team meetings (MDT) with the CNM and on the day of the visit and provided advice that discharge planning should be discussed at the point of admission and reviewed at all MDT meetings. We were pleased to hear that a discharge co-ordinator has recently been appointment and will have responsibility for facilitating discharge planning.

On the day of our visit, the William Fraser Centre had 11 patients. The atmosphere in the ward was welcoming and calm during the visit. The ward was busy with some of the patients and staff engaging in activities of daily living to promote a sense of independence. The interactions we observed between staff and patients were warm and positive. We noted that the staff we met with on the day of the visit knew the patients well.

We did, however, hear from those that we spoke with that they found the quality of food available for them of poor quality and raised issues in relation to the presentation and temperature of meals. Some of the patients told us that they prefer to eat out or purchase their own food and snacks. We asked patients how they raised concerns about their care and treatment, for example, via ward community meetings. We were told that community meetings stopped during the Covid-19 pandemic and have not yet re-started. We raised these issues with the CNM and SCN on the day and were advised that they would escalate concerns about the food to the catering management team in the Royal Edinburgh Hospital. The SCN agreed that community meetings supported patients sharing views in relation to their care and treatment and would look to reinstate these meetings as a priority.

The CNM and SCN told us that there continued to be staff shortages in the MDT which have had an impact on staff morale. We were told that to date, shortages in nursing staff have mainly been covered by the staff team. We were advised that there was an ongoing recruitment drive for staff alongside managers considering options to support current staffing in the William Fraser Centre.

We were told that in terms of staff support, the SCN had recently introduced quarterly staff meetings for each of the three units. Staff also engaged in personal developing planning (PDP) and continued to be offered training to support skill development. We heard that recent webinars have been available to staff to support with training needs. Clinical supervisors were available to staff if they chose to use this support. Psychology offered staff weekly reflective practice sessions which are well attended and viewed as positive and beneficial to staff.

Through discussion with staff and patients and from the information in the files we reviewed, we were impressed that there is strong emphasis on the value of building a nurturing and supportive relationship with patients who have experienced adversity. The CNM and SCN appeared to be invested in building the skills and knowledge of staff to ensure they have the necessary skills to deliver person centred, strengths based and solution focussed care.

Care records

Information on patient's care and treatment is held both electronically and in various paper files. We found this cumbersome to navigate and noted a lack of cohesion between paper and electronic files. We were of the view that the current recording system requires review to ensure all patient information is stored accurately and is current. We discussed this with the CNM and SCN on the day of the visit and were assured that the paper files would be reviewed as a matter of priority.

Multidisciplinary team (MDT)

Care and treatment in the ward is provided by the MDT. In addition to the nursing staff, there are two consultant psychiatrists, one consultant forensic psychiatrist, psychology staff, an occupational therapist (OT), a speech and language therapist (SALT), an art and music therapist and a recreational assistant. The majority of the patients in the ward on the day of the visit had an allocated mental health officer and/or a social worker.

Each consultant psychiatrist has a weekly MDT meeting where members of the MDT provide feedback to the clinical team, outlining the patients' progress. These meetings are held in person on the ward. The attendance of patients was variable due to ability to attend and patient choice. Families who had involvement in their relatives care were invited to attend meetings. There was evidence from the MDT records that family members, or guardians/proxies who have been appointed, were involved in decision making.

We were disappointed to see that recording of the MDT meetings was brief and lacked detail in relation to decisions made and noted a lack of future care planning. We raised this with the SCN on the day of the visit and were advised that a new MDT recording system has been introduced. The SCN added that staff were continuing to familiarise themselves with the new recording system and working towards ensuring that there is a better quality of recording for the MDT meeting.

Care plans

Of the other notes that we reviewed, including clinical notes, treatment plans and risk assessments that are held both electronically and in paper copies, we found these to be of a

good standard. We saw that physical health care needs were being addressed and followed up appropriately.

Some patients are subject to care planning approach (CPA) and we found this paperwork to be of a high standard and regularly reviewed.

The files we reviewed included details of personal history, with some files that included detailed chronologies of significant events; all had very comprehensive risk assessments.

We found the care plans to be mainly focussed on risk which we felt was to the detriment of a strengths-based approach. There was a lack of person-centred approaches in the creation of the care plans. We would have expected to see care plans that included goals, interventions and were regularly reviewed by the MDT to determine whether interventions were promoting recovery, or whether alternative strategies were required to resolve the patient's unmet needs.

We made a recommendation in the previous report in relation to the reviewing the treatment goals and we were disappointed to find that this had not been progressed. We raised this with the CNM and SCN on the day of the visit. The CNM and SCN informed us that they were implementing a programme of regular audits of care plans. This was to ensure keyworkers and the individuals they support were provided with care and treatment that was person centred, solution focussed and managed the risks commensurate within this setting.

To ensure participation and supported decision making, nurses should be able to evidence how they have made efforts to do this and that actions that are part of the care plan, have clear and attainable goals. We also found that he level of participation in care planning varied. From the care plans we reviewed, we were pleased to see methods to support involvement and participation for patients with communication and cognitive difficulties. The care plans for these patients included signs and symbols and the involvement of a speech and language therapist (SALT).

We noted some comprehensive psychological formulations in patient files. We heard from the SCN that the recent introduction of psychological formulations to patient's care and treatment is intended to enhance the clinical skills and knowledge of the staff supporting patients in the William Fraser Centre.

The continuation notes were of a high standard. The notes were very informative and personalised, with detailed information on what progress the patient had made that day.

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/node/1203

Recommendation 1:

Managers should ensure that summative evaluations are recorded in care plans that indicate the effectiveness of the interventions being carried out and that set out any required changes to meet care goals.

Recommendation 2:

Managers should implement a system for the regular audit of care plans to ensure consistency in quality of content, recording and review.

Use of mental health and incapacity legislation

Patients in the William Fraser Centre are subject to a range of mental health and incapacity legislation, in some instances patients are subject to both. On the day of our visit, ten patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('MHA') and one was subject to a Compulsion Order under section 57A of the Criminal Procedure (Scotland) Act 1995. Many of the patients were subject to Adults with Incapacity (Scotland) Act 2000 (AWIA).

In the files we reviewed, we did not find it easy to access the MHA paperwork. Due to the current system for storing and recording information, some of the paperwork was in paper files and some stored electronically on TrakCare SCI Store, making it difficult to locate. We discussed with the CNM and SCN that a consistent recording system for all legal paperwork should be adopted with immediate effect to ensure easy access to it.

On the day of the visit, we found that patients who were subject to AWI legislation had well documented details of welfare proxies and the powers granted in the welfare and/or financial guardianship. The patients we met with who are subject to guardianship under the AWI had a good understanding of what this meant for them.

Part 16 (s235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. Treatment must be authorised by an appropriate T2, T3 or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we were disappointed to note that some patients did not have a valid certificate authorising treatment. We raised this with the CNM and SCN on the day of the visit and requested an urgent review of all consent to treatment certificates.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. None of the patients in the William Fraser Centre had an advanced statement in their file. We found that other patients had limited knowledge of what advanced statements were. We discussed with the CNM and SNC the responsibility health boards have for promoting advanced statements as they are a way of ensuring that people with mental ill health, a learning disability and autism are listened too, their rights respected and gives them the opportunity to record their decisions and choices about their future care and treatment. We made suggestions of how advanced statements could be promoted in the ward and the importance of recording the reasons if a patient declined an advanced statement.

Our advance statement good practice guidance is available on our website https://www.mwcscot.org.uk/media/128044/advance_statement_guidance.pdf

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWIA must be completed by a doctor. The section 47 certificate is required by law and provides evidence that treatment complies with the principles of the Act. We were disappointed that not all of the patients had valid section 47 certificates to authorise medical treatment. We raised this with the CNM and SCN on the day of the visit and requested urgent review of all section 47 certificates.

In the files we reviewed, we found evidence of the use Adult Support and Protection (Scotland) Act 2007 legislation (ASPA). We were pleased to see that where there was a concern that a patient may be an adult at risk of harm, these concerns were reported to the local social work department to make further inquiries under section 4 of ASPA.

Recommendation 3:

Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid and record a clear plan of treatment.

Recommendation 4:

Managers should ensure the promotion of advanced statements, to provide an opportunity for patients to make decisions and choices about their care and treatment.

Recommendation 5:

Managers must ensure patients who lack capacity in relation to medical treatment have section 47 certificates and where necessary, treatment plans completed in accordance with the AWI Code of Practice (3rd ed.), to cover all relevant medical treatment the individual is receiving.

Rights and restrictions

William Fraser Centre continues to operate a locked door, commensurate with the level of risk identified in the patient group. There was an operational policy for the unit that explained the rationale for this.

The William Fraser Centre has one seclusion room. On reviewing patient files, we noted that bedroom seclusion was also used for some patients. We discussed with the CNM and SCN the use of a patient's bedroom for seclusion, raising concerns in relation to observation and use of a patient's personal and safe space for seclusion. The CNM and SCN told us that the use of seclusion is under review, with the aim that more therapeutic interventions are developed to reduce the use of seclusion. Where seclusion was used, we found it documented clearly on HEPMA, an electronic prescribing database and as part of the patient's care plan.

Our seclusion good practice guidance is available on our website.
https://www.mwcscot.org.uk/node/1243

S281 to 286 of the MHA provides a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of the visit, there was one patient recorded as requiring restrictions to be placed upon them under sections 281-286 of the MHA. We reviewed this patient's file and were disappointed to find no paperwork authorising restrictions or MDT discussion regarding the restrictions in place. On further review of patients' files, there was evidence of additional restrictions being placed on some patients, in one case high levels of restriction, that were not supported by sections 281-286 of the MHA. We discussed these concerns with the CNM and SCN advising that the Commission would expect restrictions to be legally authorised and relevant paperwork completed. We also highlighted the need for specific restrictions to be regularly reviewed with reasoned opinion and in accordance with the principle of least restriction.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

From the patients we met with, we found that they had a mixed understanding of their rights. We were pleased to see the involvement of SALT with some patients that offered additional support in understanding their legal status and related rights. We heard from patients and staff that advocacy support was easily available on the ward and were pleased to see information on advocacy displayed around the ward to support the use of the service. Many of the patients we met with told us that they had advocacy involvement and viewed this as supportive. We also heard that the patient council have started to attend the ward regularly and offer collective advocacy to patients.

We were told by some of the patients we interviewed that they had access to a legal advisor. From the files we reviewed, there was evidence of legal representation and the allocation of a curator ad litem where required.

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 6:

Managers should ensure specified persons procedures are implemented for patients where these are required to authorise restrictions.

Activity and occupation

We heard and found evidence of a broad range of activities that are available for patients in and out with the ward. On the day of the visit some patients we met with told us they had been out of the ward that day and had enjoyed their activity.

We were pleased to find activity timetables in the patient's files that recorded a programme of activities related to the patient's interests, assessed needs, goals and outcomes. There was

an activity board with details of various activities available in the unit, and across the hospital site, visible in the main area of the ward.

Activities include art and music therapy, outings to the local community parks and cafes, visits to the Hive day service (an on-site activity centre for patients) and shopping trips. From the files we reviewed on the day, there was also evidence of skill enhancement and development to support discharge planning outcomes, such as supported meal making and shopping support.

Some of the patients we met with on the day of the visit had additional social support from third sector agencies to assist in meeting assessed support needs, outcomes and future care planning objectives. This additional support was commissioned by the social work department.

Since the last visit in 2018, there has been development to the garden area. The Cyrenian's supported the development of the garden area and continue to offer regular therapeutic activity in the garden area. Some of the patients we met with on the day of the visit told us that they had planted vegetables, flowers and plants and spoke positively about this activity.

We were told by the CNM and SCN that there had been changes in the staff team who offer the activities to patients. There is a recreational and OT assistant in the ward who facilitate the majority of the activities. Nursing staff also support patients with activity and occupation. There was clear evidence of frequent one-to-one interventions and activities with staff comprehensively documented in clinical notes.

The physical environment

The William Fraser Centre continued to be well maintained with an ongoing plan of re-decoration. The entrance to the ward was bright and the environment was cleaned to a very high standard. There is art work on the walls throughout the public and ward spaces which promotes a warm and welcoming environment. The furniture and flooring in the ward communal/dining areas had recently been updated which provides a spacious and comfortable area for patients.

The patients we spoke to on the day of told us that they were encouraged by staff to personalise their rooms to make them as homely as possible. We were able to view some patients' rooms and saw that they were decorated to each patient's personal taste. There are no en-suite facilities in the William Fraser Centre although the bath, shower and toilet facilities are adequate.

There were some environmental issues such as a lack of meeting rooms which caused difficulties for family visits and for staff arranging meetings. There are plans for a new build as part of the Royal Edinburgh Hospital redevelopment project, however this work which has been in the planning phase for some years and has been further delayed by Covid-19.

Any other comments

Throughout the visit we saw kind and caring interactions between staff and patients. Staff spoken with knew the patient group well. The patients we met with on the day of the visit

consistently praised staff, adding that they provided a high standard of care and support to them.

From the staff we spoke to, we were told that working through the Covid-19 pandemic had a negative impact on staff's ability to undertake their role in the ward. We were impressed to see and hear how the staff had continued to provide a quality service despite numerous challenges, including staff shortages.

Summary of recommendations

1. Managers should ensure that summative evaluations are recorded in care plans that indicate the effectiveness of the interventions being carried out and that set out any required changes to meet care goals.

2. Managers should implement a system for the regular audit of care plans to ensure consistency in quality of content, recording and review.

3. Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid and record a clear plan of treatment.

4. Managers should ensure the promotion of advanced statements to provide an opportunity for patients to make decisions and choices about their care and treatment.

5. Managers must ensure patients who lack capacity in relation to medical treatment have Section 47 certificates and where necessary, treatment plans completed in accordance with the AWI Code of Practice (3rd ed.), to cover all relevant medical treatment the individual is receiving.

6. Managers should ensure specified persons procedures are implemented for patients where it is required to authorise restrictions.

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.

Claire Lamza
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 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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