**Mental Welfare Commission for Scotland**

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

**Date of visit:** 13 September 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 carried out face-to-face.

Meadows Ward is a 16-bedded female adult acute admission wards with a catchment area for the south west and south east areas of Edinburgh. On the day of our visit there were no vacant beds.

We last visited this service on 6 November 2019 and made recommendations in relation to developing a system to record when a patient has been provided with information about their care and treatment, ensuring there a single system for recording patient information and an audit system that reviews the information documented in the care plans. We also made recommendations around staff awareness of policies and procedures in relation to the use of seclusion and risk assessment, ensuring there are opportunities for patients to engage in devising and participating in activities and the creation of a more therapeutic and smoke free environment.

On the day of this visit we wanted to follow up on the previous recommendations as well as look at the care and treatment being provided on the ward.

### Who we met with

We met with, and reviewed the care of, ten patients; ten who we met with in person and nine where we reviewed the care notes. We did not meet with any relatives.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), a charge nurse, a consultant psychiatrist, the psychologist, the recreational assistant, and the social work community care assistant (CCA).

### Commission visitors

Kathleen Liddell, social work officer

Susan Tait, nursing officer

Kathleen Taylor, engagement and participation officer

# What people told us and what we found

## Care, treatment, support and participation

### Patient views

The majority of the patients we met on the day of the visit were extremely positive about their care and treatment in Meadows ward. The feedback included comments such as "there is a welcoming and supportive atmosphere on the ward", "staff are caring, friendly and approachable", and "I feel safe and listened to". All of the patients we met with were positive about the activities on the ward and the role of the recreational assistant.

Many of the patients we spoke to were aware of the purpose of the admission; however, they were unaware they had a care plan and lacked knowledge of discharge planning which caused a degree of anxiety for some of the patients. Most of the patients told us that they were not invited to attend the weekly ward round and did not feel involved in decision-making about their care and treatment. The patients told us that their consultant psychiatrist did meet with them after the ward round. However, this meeting was used to advise patients of the decisions made at the ward round and did not always take into account their views.

Most of the patients were aware of their rights and had access to advocacy support. One patient suggested that a welcome pack with information about the wards and rights would be beneficial to patients, so they are able to familiarise themselves with this information throughout their admission. We discussed this with the CNM and SCN on the day of the visit and were informed that a welcome pack has been devised and is awaiting approval from senior managers. We look forward to seeing this information being made available to patients in future visits.

**Recommendation 1:**
Managers should ensure there is meaningful participation of patients and their relatives/carers in care planning and decisions about their care and treatment. Patient participation should be recorded in their clinical records.

Throughout the visit we saw kind and caring interactions between staff and patients. Staff spoken with knew the patient group well. The atmosphere in the ward was calm and welcoming. We were impressed to see and hear how the staff had continued to provide a quality service despite numerous challenges, including staff shortages.

We spoke to patients on the day of the visit who had previously been in Meadows ward and other acute wards. They provided positive feedback that they felt their care and treatment in Meadows ward was more holistic and therapeutic which they found beneficial to their recovery.

We were encouraged to hear about the commitment to staff training in Meadows Ward. Psychology are currently developing trauma informed practice training, specifically for staff working in an acute setting. We were also told that all staff will complete training on human rights undertaken by the patient council. The SCN has made contact with VOCAL, Edinburgh Carers Hub, to discuss carers training for staff to highlight the importance of carer support, involvement and participation

## Care records

During our visit, we looked at patient information that is held electronically on the IT system, TrakCare. We made a recommendation in the previous report that all patient information should be stored on a single system; we were pleased to see that all patient information in now stored on TrakCare.

Care records are documented on a pre-populated template with headings relevant to the care and treatment of the patients. The information recorded in care records was of mixed quality. Some records provided detailed and personalised information that included what the patient had achieved, and aspects of the day that had been difficult. Other records did not record this level of personalised information and used language such as 'was evident on the ward' and 'kept a low profile' when referencing the patient's activities, making it difficult to discern current issues or interventions. We would expect care records to be person-centred and detail personalised information.

The records we reviewed evidenced regular patient medical reviews, which were extremely comprehensive and recorded planned interventions for the week ahead.

There was limited evidence of one-to-one interactions between nursing staff and patients however the patients we spoke to told us that they did have this type of regular contact with staff. We discussed this with the SCN who told us that nursing staff regularly spend time with patients however do not always record this interaction. The SCN advised us that IT are developing a one-to-one recording tool that will be included on TrakCare. Once in place, nursing staff will use this to record their interactions with patients.

We were pleased to find that the care records we reviewed recorded regular communication with other professionals involved in the patient's care. However we were disappointed to find that these notes did not include regular communication with families.

**Recommendation 2:**
Managers should ensure that patients' case records are person-centred and provide more detail of interactions between patients and staff.

## Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. We reviewed care plans and risk assessments that are held electronically. We found the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with robust risk management plans. We saw that physical health care needs were being addressed and followed up appropriately by the duty doctor.

We were disappointed in the quality of the nursing care plans. The purpose of the admission was clear, with patient needs identified, however there was no clear measurable goals or outcomes recorded. When we reviewed the care plans we were unable to locate robust reviews that evaluated nursing interventions and individuals' progress. We did not find consistent evidence of discharging planning and many of the patients we spoke to were unaware of plans regarding their discharge.

There was no evidence of the patients' involvement or participation in their care plans. This concerned us as the principle of participation allows and encourages patients to be involved in decisions about their care. We were also disappointed to find a lack of involvement and participation from relatives and carers.

We discussed this with the SCN on the day of the visit who told us ongoing work on care plans is required. Nursing care plans are audited using MEG, which is a system for auditing care plans and highlight areas that require improvement.

**Recommendation 3:**
Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

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

## Multidisciplinary team (MDT)

The unit has a multidisciplinary team (MDT) of nursing staff, two psychiatrists, a full-time recreational assistant and a part-time psychologist staff. The patients have access to music and art therapy one day a week, to occupational therapy (OT) staff, speech and language therapy staff, and social work. Referrals can be made to other services as and when required.

We were told that psychology support is available 2.5 days a week on the ward. The psychologist has a role with patients, and also offers staff reflective practice sessions as well as having a training remit. We met with the psychologist who told us that patient formulations will be starting on the ward, which will be beneficial to patients and the staff providing their care and treatment. Due to limited psychology capacity, not all patients have access to one-to-one interventions. We were told that the development of group work that is linked to emotional regulation and managing distress would benefit the women in Meadows Ward and would support all patients to have access to psychological support. We discussed our concerns around the limited capacity to provide psychological interventions in Meadows Ward and raised this with the CNM, the SCN and psychologist. They agreed that increased psychological input would be of benefit to the ward and they will continue to raise this issue with senior managers.

A pilot social work post (CCA) is being trialled for patients who reside in the south east locality of Edinburgh. We met with the CCA who told us that the post is split between Meadows ward and another ward in the hospital. The main role of the CCA is to support patients with discharge planning. The CCA also has links with Department of Work and Pensions, housing, wider social work and community resources that supports patients to prepare for discharge. The CCA pilot post will be reviewed, however we were told by patients and staff that to date, the CCA role has been beneficial.

On the day of the visit, none of the patients we met with had OT involvement. The OTs are not based in the ward at present; however 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. We were disappointed to find a lack of OT involvement in the care and treatment of the patients we reviewed.

We were pleased to hear that the SCN maintains links with community supports and has weekly meetings with community mental health teams to discuss the care and treatment plans of patients who are ready for discharge, or for patients who may require admission. The SCN also attends a weekly social work liaison meeting.

Each consultant psychiatrist has a weekly meeting in which members of the MDT provide feedback to the clinical team outlining the patient's progress. These MDT meetings 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 were disappointed to see that the use of SCAMPER to record discussions and decisions at MDT meetings was not being used consistently. SCAMPER is a structured clinical assessment and communication tool intended to highlight key clinical tasks to be completed for patients and to ensure that their care progresses without gaps or delays. We found MDT meeting records that lacked detail in relation to decisions made and about future care planning. We found evidence in some patient records where there had not been regular MDT meetings due to a lack of consultant psychiatrist cover and instead a medical review had been completed. Although the medical review was comprehensive and recorded forward planning and decisions, we were concerned about the lack of MDT involvement. We raised this with the CNM on the day of the visit who agreed all patients should be discussed at the MDT meeting and would raise this immediately with the consultant psychiatrists.

We were told that Meadows ward has experienced staff shortages, so bank and agency staff have been used regularly. The SCN has been in post for 6 months and the Band 6 charge nurse is new to post. There is a further Band 6 charge nurse vacancy. Many of the nursing staff in the ward are newly qualified and there is a concern about the skill mix in the nursing team. The staff we spoke to were optimistic that the new management team and additional staff will offer a more supportive working environment which will encourage retention of staff and consistency of care.

**Recommendation 4:**
Managers should ensure consistency in the implementation of MDT meetings to ensure regular, full MDT discussion and recorded decision-making for every patient.

## Use of mental health and incapacity legislation

On the day of our visit, seven of the 16 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). We found the forms relating to each patient's detention stored electronically on TrakCare.

Patients we met with, who were subject to detention under the Mental Health Act, had a good understanding of their detained status. Some of the patients we spoke to told us they experienced cognitive impairment and would benefit from information on rights being discussed with them regularly throughout their admission. We discussed with the CNM and

SCN about the benefit of staff regularly discussing rights with patients, and recording this discussion.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. No patients required consent to treatment certificates at the time of the visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. One patient required the use of a s47 certificate. The s47 certificate could be easily located on TrakCare.

## Rights and restrictions

Meadows Ward continues to operate a locked door policy, commensurate with the level of risk identified within the patient group.

Some of the patients we spoke with told us that they were subject to escorted passes as an informal patient. Many of the patients found this restrictive and did not have a good understanding of why this pass arrangement was in place. When reviewing patient files, we found that at the point of admission, all informal patients are placed on escorted pass until senior medical review has taken place. On the day of the visit, one informal patient reported their frustration at the length of time they had been waiting for a staff member to become available to escort them out of the ward. We find this practise for an informal patient restrictive and raised our concerns with the RMO, CNM and SCN on the day of the visit.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advance statement' refers to written statements made under section 274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit, none of the patients had an advanced statement in their file. We discussed this with the CNM and SCN, explaining the responsibility health boards have for promoting advanced statements, as a way of ensuring that people with mental ill health have their rights respected and gives them the opportunity to record their decisions and choices about their future care and treatment. The CNM and SCN advised that given the level of patient acuity, it is not always appropriate to discuss advanced statements however added that towards the end of admission, there should be discussion with patients regarding advanced statements. We were pleased to hear that staff are thinking about how best to support patients in Meadows ward to consider completing advanced statements and have included information on advanced statements within the welcome pack that has been developed.

Advocacy services are available in the ward and provided by the local mental health advocacy service, Avocard. We were told that Avocard attend the ward on request and provide a good service to patients who wish to engage with this service.

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 5:**
Managers and medical staff must ensure that the reasons for restrictive practices are proportionate, evidenced, understood, discussed with patients and are the least restrictive option.

## Activity and occupation

We heard and found evidence of a broad range of activities available for patients in, and out with the ward. We made a recommendation in the previous report that patients should have an opportunity to participate in activities. We were pleased to find that the ward has a full time recreational assistant who started in-post eight weeks ago. We met with the recreational assistant and were told that an initial meeting was set up with patients to discuss what activities they would like to have on the ward. The recreational assistant meets with the patients on a Friday to plan activities for the week ahead to ensure that all new admissions to the ward are given an opportunity to provide their view on activities. All of the patients we met with spoke positively about the activities on the ward and we witnessed patients taking part in activities on the day of the visit.

There is an activities board in the communal area which details activities such as arts, crafts, baking, pampering and afternoon tea that is available of the ward. The recreational assistant will also make referrals to activities out with the ward, such as the gym and gardening group if required.

There is no recreational assistant at the weekends and patients told us that there are fewer activities during the weekend. We were impressed to hear that the recreational assistant plans to build resources and make activity packs for patients to use at the weekend that will include crafts and some mindfulness-based activities such as positive affirmations.

We were told that the recreational assistant has recently completed TrakCare training and will be developing activities care plans for every patient in the ward.

## The physical environment

There were areas of the environment where décor needs refreshed, most notably the interview and meeting rooms and the courtyard. Since the previous visits, we were pleased to find that efforts have been made to create therapeutic spaces in the ward. An area has been developed near a bright window space, with the use of soft furnishings that offers a less clinical environment. Patients told us that they like this area as it is quiet and there is wildlife outside the window. Staff have arranged bird tables near this area and patients enjoy watching and feeding the birds.

The entrance to the ward has a new piece of art work painted by a patient. This promotes a warm and welcoming entry to the ward. We were pleased to be told that the SCN is developing the quiet room in the ward. There is a plan to turn this room into a multi-therapeutic space for

patients and staff to use. Equipment such as a massage chair has been ordered and it is hoped this space will support the reduction of stress and distress.

We were concerned that a contingency bed was in the room on the day of the visit, although this was not being used. We raised our concerns to the SCN that this room was not fit for purpose as a bedroom, as it is lacking in appropriate facilities. We were told that senior managers have agreed to remove the contingency bed to allow development of the quiet room. We look forward to seeing this new space during our next visit.

All of the patients have single bedrooms with en-suite facilities. The patients we spoke to told us that they are encouraged to personalise their bedrooms. Some patients reported that the temperature of the ward is cold at night. We raised this with the CNM and SCN and they advised this is a common complaint and reassured us that patients have access to extra blankets if needed.

There is a courtyard area accessible from the communal area in the ward. Patients have access to this area throughout the day. The area is closed at midnight to promote sleep. We were told that there are plans to develop the courtyard to include planters and raised beds, promoting a more therapeutic outside space.

In the previous report, there was a recommendation in relation to actionable plans being made to create a smoke free environment. We were told that patients continue to smoke in the courtyard area. We heard from staff that the restrictions imposed on patients during the Covid-19 pandemic increased smoking in the ward environment. NHS Lothian sought advice from Public Health Scotland during the first Covid-19 lockdown to permit smoking in the courtyards, and to prevent patients smoking in the ward environment due to the associated risks. The CNM and SCN told us that it will be difficult to change the current smoking arrangement. We heard that plans are in place to support a non-smoking environment. A smoking cessation worker has been employed alongside a senior health promotion worker. They plan to review all of NHS Lothian's smoking policies and support in the implementation of them.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure there is meaningful participation of patients and their relatives/carers in care planning and decisions about their care and treatment. Patient participation should be recorded in their clinical records.

**Recommendation 2:**
Managers should ensure that patients' case records are person-centred and provide more detail of interactions between patients and staff.

**Recommendation 3:**
Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the care needs of each person and identifying clear interventions and care goals.

**Recommendation 4:**
Managers should ensure consistency in the implementation of MDT meetings to ensure regular, full MDT discussion and recorded decision-making for every patient.

**Recommendation 5:**
Managers and medical staff must ensure that the reasons for restrictive practices are proportionate, evidenced, understood, discussed with patients and are the least restrictive option.

## 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.

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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