Mental Welfare Commission for Scotland

Report on announced visit to:

Myreside Adult Rehabilitation Ward, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 12 January 2023

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.

Myreside Ward is a 14-bedded female in-patient rehabilitation unit for individuals between the ages of 18 and 65. Referrals are received from many sources, including; in-patient acute services, community services and forensic services. Many of the individuals referred to Myreside have had contact with mental health services for a prolonged period of time. The objective of Myreside is to provide intensive rehabilitation to individuals with complex and enduring mental health needs, with the aim of preparing and supporting individuals with discharge into the community.

We last visited this service on 1 August 2019 and made recommendations in relation to adequate staffing levels to allow for planned activities and the development of a suitable outdoor area for patients.

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 six patients, three who we met with in person and six who we reviewed the care notes of. No relatives wished to meet with us.

We spoke with the clinical nurse manager (CNM), senior charge nurse (SCN) and members of the nursing staff team. In addition we met with the music therapist.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

Kathleen Taylor, engagement and participation officer

What people told us and what we found

Care, treatment, support and participation

During discussion with the staff team and patients and from reviewing patient files, it was clear that many of the patients in Myreside have reached their rehabilitation potential from hospital-based care. However, more than half of the patients in Myreside have been assessed as requiring continuing complex care. We heard that there were limited resources in the community for patients assessed as having continuing complex care needs. This had resulted in the current patient group having prolonged admission periods to Myreside. We were told that senior managers had recognised the gap in community service provision for patients with these specific needs and were commissioning a new service to meet this. At the time of the visit, there were no specific details about the service, however we will continue to monitor developments during future visits to Lothian rehabilitation services.

Throughout the visit we saw kind and caring interactions between staff and patients as well as a number of staff involved with patients either on a one-to-one basis or in group settings. The atmosphere on the ward was calm and welcoming. Staff spoken with knew the patient group well and appeared committed and motivated to support the patients. It was positive to note that patients we met with spoke highly of the care and support they receive from the multi-disciplinary team.

Staff told us that the team in Myreside Ward had recently been through a number of staff changes. In the past year, a new SCN and RMO had been recruited to the ward. The staff we spoke to viewed these changes as positive for staff and patients. Staff praised the new ward management team adding that they felt listened to and supported in their role and own development. We also noted good leadership during the visit.

Staff told us that the ward team were supportive of each other, creating a positive working environment. However, the team also told us that staff shortages continued to impact on their well-being and ability to undertake their role. We heard that staff regularly cover extra shifts and do not take allocated breaks, in order to allow them to complete nursing tasks. We also heard that although staff meetings were arranged, these were often cancelled due to work pressures. We discussed staff feedback with the CNM and SCN. We were told that staff well-being was paramount and support such as reflective practice and supervision continued to be a priority, however they recognised that staff shortages did impact on the availability of this support.

Feedback from patients

The patients we met on the day of the visit were extremely positive about their care and treatment in Myreside. The feedback included comments such as “staff are class”, “staff listen to me and spend time with me”, “I am involved in decisions about my care”, “I had a brilliant night at the pantomime, it made me feel good about myself”. Many of the patients told us about the recent changes in the staff group and how this had positively impacted on their care and treatment.

Patients told us that they had a key nurse who they met with regularly. Patients also told us that they had regular reviews by their responsible medical officer (RMO) and felt involved in

discussions and decisions made about their care and treatment. Most of the patients had some awareness of discharge planning, with others able to identify that they still had some goals to achieve to progress their discharge plans.

Although there were some concerns raised with us. One patient reported that they found 'boarding patients' very unsettling in the ward environment. The patient told us that as they were in a shared room, and that there were times when a boarding patient who they did not know was placed in the room, increasing their levels of anxiety and concerns for their safety. The SCN confirmed that boarding patients are regularly admitted to Myreside due to the current demand for beds across the hospital site. The SCN told us that many of the patients find this unsettling. Although we recognise the pressure on beds, we were concerned to hear that the boarding situation was negatively impacting on patients.

The patients also raised concerns that due to staff shortages, there were times when planned community activities did not go ahead. One patient told us that they felt that senior managers did not understand how important it was for patients to attend planned community activities and the disappointment experienced when these activities were unable to go ahead. The patient was of the view that managers should consider the negative impact on patients when making decisions regarding staffing across the hospital site.

We did not speak with any carers on the day of the visit. The SCN told us that prior to Covid-19, there was a carer support group in Myreside that was well-attended. The SCN and psychologist planned to restart the carer group imminently with a view to offering carer support and increasing carer involvement and participation.

Recommendation 1:
Managers should consider and review current boarding arrangements to ensure patient's safety, welfare and well-being are prioritised.

Care records

Information on patients care and treatment is held electronically on TRAKCare. We found this system easy to navigate. The majority of case records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in Myreside. It was evident from reviewing the case records that patients in Myreside required intensive levels of care, motivation and support. The patient group can experience significant levels of stress and distress that leads to increased clinical risk, due to high levels of verbal and physical aggression. We were pleased to note that the clinical team were actively involved in providing the support, care and treatment to patients at these times.

The majority of the case notes we reviewed evidenced person-centred and individualised information, detailing what activities the patient had engaged in that day and what had been positive or challenging. The clinical records completed by OT, art, music and drama therapists were personalised, outcome and goal-focussed, and included forward planning.

We were pleased to find that the care records included regular communication with families and relevant professionals.

We would expect a rehabilitation care plan to focus on goals around physical, psycho-social, therapeutic, financial, social, recreational and vocational needs. We were pleased to see that care plans took into account these goals as well as the needs and strengths of the patient. The purpose of the admission was clear and we were pleased to find that where appropriate, discharge planning was referenced in the weekly MDT meetings.

The Commission's 2020 themed visit report on rehabilitation services highlighted the link between long-term mental health problems and an increase of physical health problems. We heard on the day of the visit that many of the patients in Myreside had been in hospital for prolonged periods of time. Long hospital admissions are known to be barrier to routine and national health screening patients might otherwise have access to in the community. We were pleased to find that there was a significant focus on physical health care for patients in Myreside. There was evidence of physical health care needs being addressed and followed up appropriately by the junior doctor.

We saw evidence of a culture that supported healthy lifestyles, particularly in relation to diet, exercise and mental well-being. The recent increase in OT involvement to Myreside has supported increased patient opportunity to engage in regular exercise and support with diet and nutrition. For patients who required support with smoking, alcohol and drug addiction, we found evidence of support being offered via smoking cessation and referrals to NHS Lothian addiction services.

We found the risk assessments to be of a high standard and included an associated safety plan. The risk assessment included detailed pass documentation recording the purpose of all time out of the ward and also included a failure to return plan.

The care plans were reviewed on a regular basis and we found evidence of meaningful review and patient progress. In addition to fortnightly reviews, we also found that there were three monthly reviews through the Integrated Care Plan (ICP) process. We found comprehensive and detailed information recorded in the ICP. We were pleased to find that the ICP meeting was attended by the MDT and patient/carer and reviewed goals on mental health, risk, substance misuse, time off the ward and risk.

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

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. The Commission would expect a rehabilitation service care plan to be based on a whole-systems approach, with a clear focus on recovery.

We were pleased to find that the majority of care plans were individualised, goal focussed, person-centred and adopted a strengths based and holistic approach. Some of the care plans we reviewed contained detailed information, however this was recorded in a prescriptive manner and lacked a personalised and person-centred approach. We discussed this with the

SCN on the day of the visit who acknowledged that their care plan audits had identified some ongoing training needs in nursing care planning. There was evidence of patient involvement in many care plans, with most of the patients we met telling us that they had been actively involved in compiling these and had added personalised information, such as how they liked staff to communicate with them and how they feel best supported. Other patients reported that they had not been involved or had chosen not to have involvement in their care plan. For these patients, there was evidence in the care records that staff continually encouraged patients to participate in their care plan. We discussed the reluctance of some patients to engage and were pleased to hear that in order to support patient participation in care planning, Myreside staff were using psychological formulations, for patients with assessed complex care needs. The formulation sessions inform how best the MDT can support the patient, as well as supporting staff to reflect on their expertise, and how this can generate new ways of working with patients.

However, we found that there was variation in the completion of continuation notes, as not all staff used the pre-populated template to record nursing observations. Where the notes indicated high levels of activity, for example, overnight, we would expect a consistency of approach with regards to recording. We highlighted this to CNM and SCN on the day of our visit.

There was also variation in the frequency of recorded one-to-one interactions between patients and nursing staff. Where one-to-one interactions were noted, they were comprehensive, personalised and person-centred. We raised this with the SCN on the day of the visit who confirmed that nursing staff had regular one-to-one interactions with patients, however staff did not always record the interaction on TRAKCare. The SCN added that many patients refused this type of support from staff, however staff were not recording that this intervention has been offered and refused. We were aware from other visits that TRAKCare does not have a specific section at present to record these interactions. We were pleased to hear that there was a quality improvement project taking place to review how rehabilitation services record information on TRAKCare. One of the aims of this project was to encourage and improve the documentation of one-to-one interaction with patients.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a full-time consultant psychiatrist, junior doctor, psychologist, psychology assistant, art, music and drama therapists.

The multi-disciplinary team (MDT) work closely to provide psychological therapies, psycho-education programmes and support individuals to develop meaningful activities and strategies to help them through their recovery journey. The OT input into the ward has recently increased from one part-time OT to two part-time OT's. We were told by staff and patients that this increase has had a positive impact.

We heard that there are nursing staff vacancies and a full-time band 5 OT vacancy. Bank staff were used regularly to cover staffing shortfalls. We were told that the ward had a core group of bank staff who regularly worked on the ward to support the continuity of care delivery. The CNM and SCN told us that there had been initiatives to support recruitment.

The MDT met weekly in the ward. The patients were split into two groups and each patient group was discussed on a fortnightly basis. Patients who wished to attend the MDT meeting placed their name on a list to ensure their participation in the meeting. Nursing staff met with the patients prior to the meeting to discuss what patients want to be discussed. On review of the patient files and from speaking with patients, we saw evidence of active patient engagement, and where appropriate, family participation in the MDT recording.

The MDT meeting was recorded on TRAKCare. We found detailed recording of the MDT discussion, decisions and personalised care planning for the patients. We were pleased to see clear links between MDT discussion and the care plan outcomes. It was clear that everyone in the MDT was fully involved in the care of patients in Myreside. We saw that where discharge planning was progressing, the community rehabilitation team (CRT) were involved to support discharge.

Use of mental health and incapacity legislation

On the day of our visit, all 13 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). One patient was subject to Adults with Incapacity (Scotland) Act 2000 (AWIA). We found the detention certificates relating to the Mental Health Act and AWIA stored electronically on TRAKCare.

On the day of the visit, we found that patients who were subject to AWIA legislation had documented details of welfare proxies and the powers granted in the welfare guardianship.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Part 16 (s235-248) of the Mental Health Act sets out conditions under which medical treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. Medication given beyond two months must be authorised by an appropriate T2 or T3 certificate. On reviewing electronic prescribing and paper files, we found that some patients were prescribed medications that were not properly authorised by their T3 certificate. We raised this with the CNM and SCN on the day of the visit and contacted the RMO following the visit to request an urgent review of all unauthorised medication and the patient consent to this treatment.

When treatment had been given to a patient without the correct legal authority in place, we advised that the patient and their named person should be informed that there had been of the period of unauthorised treatment, and their rights in relation to this.

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 certificate is required by law and provides evidence that treatment complies with the principles of the AWIA. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found evidence of section 47 certificates for patients who required this.

In the files we reviewed, we found evidence of the use Adult Support and Protection (Scotland) Act 2007 legislation. 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 the Act.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, up to date and accurately reflect the current medication prescription.

Rights and restrictions

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

The patients we met with during our visit had a mixed understanding of their rights and detained status, where they were subject to detention under the Mental Health Act. All of the patients we met with were aware of their right to advocacy support and some had legal representation. We were pleased to see information that had been sent to the patient by the RMO, detailed their legal status, their rights in relation to this and contact numbers for advocacy to support patients to exercise their rights. We noted that ICP meetings also reviewed patient rights.

Patients we met with told us that there was a community meeting in the ward every week organised by nursing staff. The meeting was an opportunity for patients to communicate their views on any issues in the ward and discuss these with each other and with staff. The community meeting also provided an opportunity for patients to make suggestions regarding activities and/or social events they would like arranged in the ward.

S281 to 286 of the Mental Health Act provide 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 Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. One patient was specified on the day of the visit. We were able to locate the paperwork authorising the restrictions. On the day of the visit there was no reasoned opinion recorded on TRAKCare. This was discussed with the RMO, who was able to provide the paperwork the following day.

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

When we are reviewing patient files we look for copies of advance statements. The term ‘advance statement’ refers to written statements made under ss274 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 only one patient had an advance statement in their file. We discussed the low uptake of advance statements with the SCN who told us that nursing staff do have discussions with patients regarding the benefit of advance statements. These discussions were evidenced in the case records, as well as during ICP meetings. It was evident during review of the patient files and during discussion with some of the patients that they

were not at a point of their recovery to be able to make decisions regarding their care and treatment. We were told by the SCN that for patients who were considering making an advance statement, advocacy was contacted to support the patient in this process.

Advocacy services were available in the ward and were provided by the local mental health advocacy service, Avocard. We were told that advocacy attend the ward on request and provide a good service to patients who wished to engage with them. We were pleased that all of the patients we met with on the day of the visit had advocacy support.

The Royal Edinburgh Hospital has a patient council group that offer collective advocacy and drop-in sessions that some of the patients in Myreside attend.

We were impressed to hear that the patient council had recently delivered human rights-based training to patients and staff, promoting rights-based care to patients.

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

We heard and found evidence of a broad range of activities that were available for patients in Myreside Ward. The activity and occupation in the ward was provided by OT's, nursing staff, music, art and drama therapists. The patients we met with spoke very positively and were complimentary about the activities offered in the ward and out in the community.

There was an activities board in a communal area of the ward that included activities on offer and an area for patient suggestions. The activities available included music, art and drama therapy, swimming, therapet, smoothie group, arts and crafts, mindfulness groups, quizzes, karaoke, bingo and gardening group. We were pleased to see that patients could also access activities out with the ward, some of these being provided by third-sector providers. These activities included the Hive, where patients could engage in activities and socialise with other patients in the hospital. Some patients attended the Glasshouses for gardening activities with support provided by the Cyrennians and Artlink. We were impressed to hear that some patients had developed an interest in gardening and were now involved in growing their own vegetables.

We met with OT staff on the day of the visit who told us that there were plans for new activities which had been informed by patient views and suggestions. The patients in Myreside Ward had asked OT's for a woman's group to discuss pertinent issues, and this will also include peer support involvement. We were impressed that the recent increased OT input has made a positive impact on patient activity and occupation in short space of time.

We also saw and heard that patients were offered activities to enhance daily living skills. Patients were supported to 'deep clean' their room weekly with the support of the house keeper, domestic staff and their key nurse. Patients had set days for laundry and were supported to launder their own clothes. For some patients, cooking their own meals in the

kitchen with the support of staff was part of their care plans. For patients who engaged in the cooking programme, a weekly food budget was provided by the ward to purchase food.

We were concerned to hear from patients and staff that due to staff shortages in other areas of NHS Lothian, planned individual and group activities can be cancelled at short notice. Staff we spoke with told us that they felt having to cancel planned activities impacted on the therapeutic relationships they had with patients as well as impacting on staff morale. The issue of short staff impacting on patient activity and occupation was raised in the previous report. Whilst we acknowledge the challenges of staff shortages, we were concerned that this compromised continuity of care and negatively impacted on the patient's rehabilitation goals. We raised this with the SCN and CNM on the day of the visit who shared our concerns over staff shortages and the impact on patients and staff. The CNM advised that these concerns continue to be raised with senior managers.

Recommendation 3:
Managers should continue with their efforts to address the significant staffing shortages in the ward in order to minimise the impact on patient care.

The physical environment

Myreside was located on the second floor of the original part of the Royal Edinburgh Hospital. The layout of the ward consisted of single rooms and double rooms. There were shared toilets, showers and one bathroom. The double rooms had recently undergone some renovation work and there was now a secure partition between bed spaces in place which supports a level of privacy and dignity for patients. We were able to view a single and double room. Both were personalised and clean. There remains an issue with storage and some of the patient's belongings were stored in plastic boxes.

There was a lounge area and a separate dining area for the patients. Both of these areas had recently undergone decoration work and were bright and spacious with new furniture, art work and plants, promoting a more homely environment. We were told by the SCN that further decoration and renovation work was planned to create more meeting room space on the ward.

There was a recommendation in the previous report in relation to provision of outdoor space and garden areas for patients in Myreside. We were disappointed to see that there had been no progress on implementing this recommendation. Although we recognise the location of Myreside Ward makes it difficult to provide outdoor space, the lack of access to outdoor space continues to concern us. We consider it fundamental that patients have access to outdoor safe space, especially patients who are experiencing stress and distress. From conversations with patients and staff, there was a clear consensus that if patients had garden space to access during times of stress and distress, it would help manage some behaviours more therapeutically, instead of using other interventions, such as medications, to manage distressed behaviours.

We heard about issues in relation to smoking on the ward. There was a ward policy in place and agreement from the patients that they will hand over cigarettes and lighters to staff when entering the ward. The smoking agreement was discussed regularly with patients at community meetings including discussions around risks factors. The community Fire Officer

had also attended the ward to highlight the risks of smoking on the ward. Patients were offered support from smoking cessation, however the uptake of this support had been low with many patients clear that they did not wish to stop smoking. Although attempts were being made by the team to prevent smoking on the ward, it remained problematic. Nevertheless, the clinical team were continually considering alternative ways to further reduce smoking. The team identified that night time was difficult for patients who smoked, therefore a review of patient pass time was undertaken to support patient pass at these times. We were told that this strategy had supported a reduction in smoking on the ward at night.

Although the patients did not raise any issues regarding the environment, there were evident disadvantages to patients being in Myreside, in comparison to patients in the new part of the hospital building. We were concerned that individual's right to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, were being compromised due to the environmental factors. We were aware that plans for a new build as part of the Royal Edinburgh Hospital redevelopment project were in place, however this work is some years away and had been further delayed by Covid-19.

Recommendation 4:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all patients in the Royal Edinburgh Hospital.

Any other comments

We were encouraged to hear about the commitment to development of Myreside and the other rehabilitation services in the Royal Edinburgh Hospital. We were impressed to hear from the CNM that every service involved in rehabilitation care and treatment met on a monthly basis to discuss service gaps, highlight areas of improvement which were required and assess what was working well. The CNM had been making links with rehabilitation services in other health boards to discuss new practice ideas, view different environments and consider any new care and treatment that would be beneficial to the patient experience in Myreside.

Summary of recommendations

Recommendation 1:
Managers should consider and review current boarding arrangements to ensure patient's safety, welfare and well-being are prioritised.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, up to date and accurately reflect the current medication prescription.

Recommendation 3:
Managers should continue with their efforts to address the significant staffing shortages in the ward in order to minimise the impact on patient care.

Recommendation 4:
Managers should consider ways to achieve parity in relation to the ward environment, garden access, privacy and dignity for all patients in the Royal Edinburgh Hospital.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk