Mental Welfare Commission for Scotland

Report on announced visit to:

Cedar and Hawthorn Wards, Orchard Clinic, Royal Edinburgh Hospital, Morningside Place, Edinburgh EH10 5HF

Date of visit: 26 & 27 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.

The Orchard Clinic is a 40-bedded, medium secure forensic unit on the Royal Edinburgh Hospital site. In addition to an acute admission ward, there are two forensic rehabilitation wards in the clinic. Cedar is a 14-bedded rehabilitation ward for men. Hawthorn is a mixed-sex 11-bedded rehabilitation ward.

We last visited the rehabilitation wards at the Orchard Clinic on 28 and 29 June 2021 and made recommendations about improving and auditing nursing care plans, ensuring the correct legal authority was in place for all medication prescribed under the Mental Health Act and auditing the same. We also raised again concerns about environmental risks relating to patients' en-suite bathrooms, which had been an ongoing issue for a number of years.

On this visit we wanted to follow up on previous recommendations and to find out about patients' experiences of rehabilitation following the easing of Covid-19 restrictions.

The visit was carried out over two days, to enable patients on each wards to have plenty of opportunity to meet with us. This visit was carried out in the wake of a number of serious complaints made in relation to the care and treatment of patients in Redwood Ward, the acute admission ward in the clinic (which we had already visited a few months previously). We wanted to ensure the same issues of concern were not also present in the rehabilitation wards.

Who we met with

We met with four patients and reviewed the care and treatment of seven patients. No relatives asked to meet with us.

We spoke with the service manager, senior charge nurses (SCNs), members of the nursing team, and consultant psychiatrists.

In addition we liaised with Advocard, the hospital advocacy service.

Commission visitors

Juliet Brock, medical officer

Lesley Paterson, senior manager (practitioners)

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we spoke with on both wards were almost all very positive about nursing staff and the care and support they were receiving. Staff were described as approachable, patients told us they felt confident in them and that if they had any concerns or felt unsafe they would have no hesitation in speaking with staff. One patient told us they had been in many in-patient units over the years and spoke glowingly of the staff they had encountered on the ward in contrast to their past experience.

One patient disclosed to us that they had previously had very negative experiences on Redwood ward. With the patient's consent, we passed on the details to senior managers in relation to the ongoing investigation.

We had been aware for some time of staffing pressures across the clinic and the considerable challenges this was placing on the ward staff teams. Some patients were aware of this and spoke of the impact that this has at times. One patient commented "if there's three staff all day we know we're not getting passes, but it's only happened a few times".

Multidisciplinary team (MDT)

In addition to medical and nursing staff, the wards had input from occupational therapy and psychology, along with the involvement of art and music therapists based in the clinic. The peer support worker continued to provide input to the wards and both patients and staff spoke very positively about this support.

We were advised that a clinical pharmacist also worked in the clinic and attended MDT meetings. Input from other professionals such as dietetics and physiotherapy was available on referral.

Previously, a GP was attached to the clinic and carried out surgeries on a regular basis to review any physical health problems patients had. Unfortunately the post was vacant at the time of our visit. The ward doctor told us they were reviewing patients' physical health and developing a system for monitoring this on an interim basis, in the absence of a GP.

Care records

Most of the patient records were held electronically on TRAKcare, the electronic record system in use across NHS Lothian. A few documents were incompatible with electronic records and were stored separately on paper files.

Daily care notes were generally detailed and well recorded with evidence of patients participating in activities. Entries in the notes were also evident from psychology and occupational therapy.

Clinical team meetings were well documented, with a clear record of those attending, of clinical discussions and of ongoing plans.

There was evidence of regular medical reviews and of periodic care programme approach (CPA) meetings. CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by

involvement of a range of different people and by keeping the individual and their recovery at the centre. The CPA records we viewed were highly detailed.

Care plans

Similar to our last visit, in the files we reviewed, the quality of nursing care plans was variable. In many we could not find evidence of patient participation or of the patient signing their care plan. Although care plan reviews often appeared to be carried out regularly, often monthly, many reviews lacked meaningful clinical detail. We suggest further improvement work is undertaken in the area of care planning.

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 carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Use of mental health and incapacity legislation

All patients were detained under the Criminal Procedures Scotland Act 1995 (CPSA) or the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status.

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.

Consent to treatment forms (T2) and certificates authorising treatment (T3) are not held on HEPMA, the hospital electronic prescribing system. We were pleased to find that Hawthorn Ward kept a folder of paper copies of the latest Mental Health Act documentation authorising treatment for individual patients. This enabled doctors prescribing medication, and nurses dispensing medicines to easily check the correct legal authority was in place to authorise treatment. We found that the appropriate T2 and T3 documentation was in place in the cases we viewed and corresponded to the medication being prescribed.

All documentation pertaining to the MHA and CPSA was in place in the files we reviewed.

Rights and restrictions

Patients welcomed the lessening of restrictions that had been present earlier in the pandemic, which had led to improved rehabilitation opportunities, as well as visiting from family.

At the time of this visit, NHS Lothian Covid-19 restrictions meant that visiting was still limited to patients having two, one hour visits a week, with a maximum of two people per visit. Visits had to be booked in advance.

We were pleased to hear that independent advocacy services were running on a more routine basis again and that patients were accessing advocacy for advice, and for support with appeals and attending Mental Health tribunals.

Where specified person restrictions were in place under the MHA, reasoned opinions should be in place. We found this missing in one of the cases we reviewed and we could not find copies of the required specified person documentation.

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

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:
Where patients are subject to restrictions under specified person legislation, the RMO must ensure that a reasoned opinion is completed and accessible in the notes, along with the required specified person documentation.

Activity and occupation

Activity provision had been severely impacted during the pandemic, however access to this had continued to improve since we last visited.

A wide range of activity groups were run by OTs and therapists in Cypress unit. These included cooking sessions, art and music therapy, gardening and IT, as well as sports and physical activities in the gym hall such as badminton and yoga. A number of patients spoke of enjoying activities on Cypress.

Patients with passes could participate in activities outside the clinic, in the hospital grounds, including the Cyrenians Gardening project and activity sessions at the Hive. We heard that some patients were also beginning to access opportunities for activities in the community again.

For patients with limited passes, particularly in Hawthorn Ward, it was noted that opportunities for therapeutic activities could be limited. Although ward staff tried to facilitate activities on the ward, this could be limited due to staffing pressures. It was acknowledged by the charge nurse that there were times when there were insufficient staffing numbers to facilitate activities and support patient's rehabilitation plans. We discussed whether the addition of an activity co-ordinator could be beneficial to Hawthorn ward. We were advised this was something that had been considered, but that no funding had been identified.

Recommendation 3:
Managers should review the opportunities for patients on Hawthorn Ward to engage in therapeutic activities and consider the need for an activity coordinator.

The physical environment

Cedar Ward

On Cedar ward we noted the lounge walls were freshly painted and there was new furniture throughout the communal area, including comfortable chairs in the TV space.

There was a quiet room on the ward and visitors could meet with their relative in the dining room, in the quiet room, or out with the ward, depending on what permissions their relative had in place.

Hawthorn Ward

Hawthorn was also clean and freshly painted. In addition to the main TV lounge, which had been refurbished with new furniture, there was a separate lounge which had been decorated by one of the healthcare assistants (HCA). We saw patients also enjoying sitting in this space having breakfast. Another quiet room on the ward, also decorated by the HCA with patients assisting, was furnished to feel more homely, with comfortable seating, a fireplace and items of décor and artificial plants. The dining room is accessed just off the ward. Patients usually had their breakfast on the ward.

The bedrooms on both wards were en-suite. We noted continued issues with ligature points in the en-suite shower rooms. We had been advised by managers that the long awaited refurbishment of all patient bathrooms across the clinic had been prioritised, that senior management were involved and it was hoped that arrangements to start the works would be made in the near future.

At the time of publishing this report, we were advised that the bathroom refurbishments were about to start in a phased schedule of works across the clinic.

Shared garden

The garden space was shared between the two wards. We were told the space was well used by patients during the summer months. As well as recreational seating areas, patients had been growing vegetables in the beds. The overall appearance of the garden furniture, paved areas and the external woodwork of the building was quite tired and somewhat neglected. We noted that it continued to compare poorly with that available for many other in-patient wards on the hospital site. The large outdoor basketball court was also in need of attention and we were told it had not been used for a few years for safety reasons, due to moss growing on the surface, which required specialist cleaning. We were told of ideas to install an outdoor gym for patients to use, which would be a welcomed addition.

Recommendation 4:

Managers should ensure the garden space is upgraded and staff teams work with patients to develop ideas to maximise use of the recreational outdoor space to best meet the needs of the patient group.

Any other comments

At the time of this visit, as at the last visit, the patient group on Hawthorn Ward included two women, both of whom we met. No concerns were raised by patients or staff about the mix of male and female patients on the ward or any issues arising from this. Again, this is an area

the Commission will continue to monitor on future visits, given the general acknowledgement of the need for single sex provision in medium secure care.

The Commission continues to be aware of the delays patients experience in moving between levels of security in forensic services, primarily due to limited resources in national provision. On this visit, we were advised of a waiting list for rehabilitation admissions. As at the last visit, discharges to lower secure settings were also delayed in some cases due to lack of availability of beds. We will continue to monitor individual cases where there are ongoing delays.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Where patients are subject to restrictions under specified person legislation, the RMO must ensure that a reasoned opinion is completed and accessible in the notes, along with the required specified person documentation.

Recommendation 3:
Managers should review the opportunities for patients on Hawthorn Ward to engage in therapeutic activities and consider the need for an activity coordinator.

Recommendation 4:
Managers should ensure the garden space is upgraded and staff teams work with patients to develop ideas to maximise use of the recreational outdoor space to best meet the needs of the patient group.

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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