Mental Welfare Commission for Scotland

Report on an unannounced visit to:

Balcarres Ward (adult acute admission ward), Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 20 March 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.

Balcarres Ward was previously a 16-bedded adult acute mental health assessment, care and treatment ward for adult males. Balcarres Ward covers the catchment area that includes the north-west and east areas of NHS Lothian. On the day of the visit, the bed capacity had been increased to 19 beds with the use of three 'flex beds' from the adjoining ward, Craiglockhart. However, there were actually 21 inpatients on the day of the visit, with two patients on overnight pass. While efforts were made to secure additional staffing to reflect the increase in bed numbers and acuity, this was not always possible, due to pressure and priorities across the hospital site. This left us with some concerns regarding safe staffing levels.

Several of the patients in Balcarres Ward were delayed in being discharged from the ward. We were told that the delays in discharging patients was in relation to a lack of community services and capacity issues in other parts of the service, mainly rehabilitation services.

We last visited Balcarres Ward on 17 September 2019 and made recommendations about care planning, recording, rights-based care, patient's engagement and the 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 six patients. We met with five in person and we reviewed six sets of care notes. We did not meet any relatives or carers on the day of this unannounced visit. We advised the senior charge nurse that we would be happy to make contact with any relatives or carers following the visit, if they wished.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), one of the consultant psychiatrists, staff nurses, nursing assistants and the recreational nurse.

Commission visitors

Kathleen Liddell, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients we met on the day of the visit were mainly positive about their care and treatment in Balcarres Ward. The feedback included comments such as “it’s brilliant”, “staff are kind and gentle”, “I like it as staff spend time with me”. All patients were able to identify a member of the clinical team that they had established a positive working relationship with. All patients we met with told us that they had daily one-to-one interaction with a member of the nursing team and valued this support.

Most of the patients we met with told us that they enjoyed the activities on the ward. The patients were especially complimentary about the music therapists input.

Some patients told us that they had a key nurse who they met with regularly; some did not know who their key nurse was. Patients also told us that they had regular reviews with their responsible medical officer (RMO), however did not always feel involved in discussions and decisions made about their care and treatment. None of the patients we met with had been involved in the compilation of their care plan. All of the patients we met with told us that they were invited to attend weekly ward rounds alongside family/carers and were able to give their views at these meetings.

Many of the patients we spoke to were unaware of discharge plans. One patient we met with told us that he was “fit was discharge” however this had been delayed due to a lack of provision of community support. The patient told us that the delay caused them high levels of frustration and told us this was “detrimental” to their mental health.

Some the patients told us that the quality and portion size of the food was unsatisfactory. One patient reported that the cleanliness of the ward was poor at times.

The patients spoke about regular staff shortages, with bank and agency staff being used frequently. One patient told us that there were lots of “different faces” in the ward which could be unsettling. The patients also told us that the ward could be extremely busy, making it difficult to find any quiet space.

Throughout the visit, we saw kind and caring interactions between staff and patients. Staff we spoke with had excellent knowledge of the patient group and appeared compassionate, empathic and dedicated. Patients praised the staff for their kind and supportive approach to their care and treatment.

Staff managed the unannounced visit well. Staff were transparent about current challenges in the ward setting and areas that required improvement.

Care record

Information on patients care and treatment was held electronically on TrakCare. We found this easy to navigate. We were pleased to find that the recommendation in the previous report had been actioned, with all information now stored on a single system.

The majority of care records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in Balcarres Ward. It was evident from

reviewing the care records that there were high levels of patient acuity in Balcarres Ward. The patient group could experience high levels of stress and distress, leading to increased clinical risk, with high levels of verbal and physical aggression. We were pleased to note that the multidisciplinary team (MDT) were actively involved in providing the support, care and treatment to patients at these times.

The information recorded in care records was of mixed quality. Some care records provided detailed and personalised information, which included what the patient had achieved and aspects of the day, which had been difficult. Other care records did not record this level of personalised information and used language such as, as 'evident on the ward' and 'low profile' making it difficult to discern current issues or interventions. We would prefer to have seen care records that were person-centred and detailed personalised information.

We were pleased to see comprehensive care records from some members of the MDT. Those documented by art and music therapists were personalised, outcome and goal-focussed and included forward planning. We were encouraged to see regular and comprehensive review of patients by the consultant psychiatrists. We were disappointed to find that activities and occupation was not recorded in care records and we also noted a lack of OT recording in care records.

We were disappointed that we were unable to find recording of one-to-one interactions between patients and nursing staff, as we heard from the patients that we met with told us that they had these daily contacts with staff; however, this was not evident in the care records. We raised one-to-one recording with the SCN on the day of the visit who confirmed that nursing staff had regular interactions with patients, however staff did not always record this as a one-to-one session on TrakCare. The SCN told us that given issues with staff shortages and bed capacity in Balcarres Ward, there were significant workload pressures on nursing staff that had impacted on the quality and frequency of recording these contacts with patients.

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

Recommendation 1:
Managers should ensure that all members of the MDT involved in a patient's care, record their contact in the care records. Care records should be personalised, goal and outcome focussed 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 that ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

When we last visited the service we made a recommendation that care plans should be personalised, include more detail and evidence the involvement of the patient. We were disappointed to find that there had been no progress in the quality of care plans. The care plans we reviewed were perfunctory and did not evidence strengths-based, goal or outcomes-focussed interventions. There was some evidence of discharge planning for patients,

including referrals to other hospital and community based services, however this was not robust and there was a lack of detail in relation to progress towards discharge.

There was no evidence of patient involvement or participation in the care plan and this was endorsed by patients we spoke to, who told us that they did not have any involvement in the completion of their care plan. This concerned us, as the principle of participation allows and encourages patients to be involved in decisions about their care.

We found the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk. We saw that physical health care needs were being addressed and followed up appropriately by the junior doctors.

When we reviewed the care plans we were unable to locate robust reviews that included summative evaluation regarding efficacy of intervention, targeted nursing intervention or the individuals' progress. We discussed this with the SCN on the day of the visit and were told that reviews were happening but were not being reflected in the paperwork. We recommended that an audit of care plan reviews was carried out to ensure that they reflect the work being done with individuals working towards their care goals and that the reviews were consistent across all care plans.

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 2:
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 3:
Managers should ensure care plan reviews are meaningful, include the effectiveness of interventions and reflect any changes in the individuals care needs.

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 were two consultant psychiatrists, junior doctors, pharmacy, art and music therapists. There was no dedicated occupational therapist (OT) for the ward and we were told that OT's attend the daily rapid run down and will become involved with any patients who require OT assessment or involvement.

We heard that there were nursing staff vacancies and high levels of staff sickness in the ward. Bank staff were used regularly to cover staffing shortfalls. We were told that the ward attempted to use a core group of bank staff to support continuity of care delivery. Nevertheless, this could not always be achieved and patients told us that they found unfamiliar staff unsettling. The CNM and SNC told us that there had been ongoing initiatives to support recruitment.

We were concerned to hear that there was no regular psychology input into Balcarres Ward. If a patient required psychological input, a referral could be made to the psychology service. We were aware that other adult acute wards across the hospital site had regular psychology input and were concerned about the lack of parity across the service. It was evident from reviewing the patient files, meeting patients and conversations with staff that the patients in Balcarres Ward would have benefitted from having access to regular psychological support. We raised our concerns with the CNM and SCN who agreed that psychological input would be of benefit to the ward and they will continue to raise this issue with senior managers.

Each consultant psychiatrist held a weekly ward round in the ward, attended by the MDT. There were options for patients and families to attend the ward round virtually if preferred, which was encouraging as it supported family/carer participation and engagement. Patients and family/carers were invited to attend the ward rounds and could book a timeslot. We saw evidence of patients and where appropriate, family members/carers attending the ward rounds and being involved in discussion and decision making.

The MDT ward round was recorded on TrakCare on a new template that was being trialled called, 'mental health structure ward round template'. The template had headings relevant to the care and treatment of the patients in Balcarres Ward. We found detailed recording of the MDT discussion, decisions and personalised care planning for the patients.

Recommendation 4:
Managers should urgently review the level of psychology provision in the ward.

Use of mental health and incapacity legislation

On the day of our visit, 15 of the 21 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a mixed understanding of their detained status where they were subject to detention under the Mental Health Act. The files we reviewed evidenced involvement of legal representation and advocacy to support with understanding of legal status and exercising of rights. All documentation relating to the Mental Health Act was stored electronically on TrakCare and easily located.

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. We reviewed all patients consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We were concerned to find that there were several patients where there was no authority to treat. There was a significant number of patients that had medication prescribed which was not authorised by the T2 or T3 certificates.

We raised this with the CNM and SCN on the day of the visit and requested an urgent review of all T2 and T3 certificates. We were told that pharmacy has raised concerns regarding T2 and T3 certificates with the RMO's during ward rounds, however the issues had not been rectified. We provided advice on informing the patient and named person of the period of unauthorised treatment and their rights in relation to this.

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.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We noted that one patient had a section 47 certificate in place. On review of the certificate, we noted that it had expired. We raised this with the SCN on the day of the visit who was unclear if the section 47 certificate was still required. The SCN agreed to request an urgent review of the need for a section 47 certificate for this patient.

Recommendation 5:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment and introduce an audit system to monitor this.

Rights and restrictions

Balcarres Ward continued to operate a locked door, commensurate with the level of risk identified in the patients group.

We made a recommendation in the previous two reports regarding the ongoing promotion and recording of patient's rights. We were pleased to see some progress in the promotion of rights in the form of a letter, sent to patients who were subject to detention under the Mental Health Act, by the RMO. The letter detailed the patient's legal status, their rights in relation to this and contact numbers for advocacy to support patients to exercise their rights. Nevertheless, the patients we met with had a mixed understanding of their rights and detained status. On review of the patients' files, we did not find records of ongoing discussion regarding rights. This concerned us and we would prefer a more proactive approach to rights based care being offered to patients in Balcarres Ward. We raised this with the CNM and SCN on the day of visit and made suggestions as to how rights information could be promoted in the ward environment with the use of QR codes and information from the Mental Welfare Commission website.

We were told 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 staff.

When we are reviewing patients' files, we looked for copies of advanced 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. We did not find any advance statements. Some of the patients we met with told us that they knew what an advance statement was and had made a choice not to complete one. Other patients did not have an understanding of advance statements. It was evident during review of the patient files and during discussion with some of the patients that

they were not at a point in their recovery to be able to make decisions regarding their care and treatment. We were told by the SCN that for patients who are considering making an advance statement, advocacy is 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 attended the ward on request and provided 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 were aware of advocacy support, if they wished to use it.

The Royal Edinburgh Hospital had a patient council group that offered collective advocacy and drop in sessions that some of the patients in Balcarres Ward attended.

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

Activity and occupation

We heard and found evidence of a broad range of activities that were available for patients both in, and out with the ward. The activity and occupation in Balcarres Ward was provided mainly by the recreational nurse, however OT's, music and art therapists also provided this support to patients.

There was an activities board in the sitting/dining area. The activities available included pet therapy, walking groups, juggling, music jam and creative writing. We were pleased to see that activities were also arranged for evenings and weekends, although these were mainly group activities such as karaoke, disco and quizzes. The Royal Edinburgh Volunteer Hub provided some activity input into Balcarres Ward, including a weekly sports/exercise and a therapet dog volunteer. We were told that the patients also attended activities in The Hive, which was based in the hospital grounds and supported by SAMH. The patients we met with spoke very positively and were complimentary about the activities offered in the ward.

Each patient had an activity and occupation care plan. The care plan recorded what groups patients had attended. We were disappointed that there was no information recorded in the care plan or case records in relation to the patient's levels of engagement and participation in the activity or the therapeutic benefit to the patient.

Recommendation 7:
Managers should ensure that activity participation is recorded and evaluated and that activity care plans are person centred reflecting the individual's preferences, care needs and outcomes.

The physical environment

The ward environment required some improvement, to promote a less clinical and more welcoming, homely and therapeutic environment. In particular, the visitors and interview room required improvement to create a softened space, especially for family contact. The lounge and dining area were brighter with some artwork and a painting of a recovery tree with some inspiring quotes from previous patients. The patients were able to use the kitchen facilities to make a hot drink and snack and had access to the outside courtyard until midnight. We were impressed that a board with staff photos, title and information was situated in the communal area to support patients and family members identify members of the staff team.

On the day of the visit, the cleanliness of the environment was a concern. There was debris and stains on the floor. Some of the bedrooms were untidy and cluttered. The corridor leading to the courtyard smelled of cigarette smoke and there was evidence of discarded cigarette ends and ash on the corridor floor. The courtyard was littered with cigarette ends. We were told that the ward cleanliness was usually of a much higher standard; however, the regular domestic staff member was not at work. We were told that there had been domestic cover in the ward.

We had concerns over the use of rooms in the ward. On the day of the visit, the quiet room had a surplus bed in it. We were told that one of the interview rooms had also been used as a bedroom on occasion. Neither of the rooms had washing or toilet facilities, compromising the patients right to privacy and dignity. These rooms were not being used as bedrooms on the day of the visit, however the quiet room was not available to be used by the patients. Although we recognised the national shortage of mental health beds, we did not consider these rooms appropriate or safe as patients' bedrooms. Furthermore, we were concerned that by using these spaces as bedrooms, there was no therapeutic or quiet space available on the ward for patients to use. The ward environment was busy and loud at times and we would suggest that patients would benefit from having a quiet and therapeutic space to utilise.

On reading patients' files and from discussions with staff, we found that patients admitted to Balcarres Ward regularly board in other wards at night, across the hospital site. The information recorded in the clinical notes and feedback from staff raised concerns that boarding could be very unsettling to patients, negatively impacting on recovery and in some instances had caused significant deterioration in patient's mental health. Some patients had been reluctant to go out on pass due to fears that they will not have a bed on return. We heard that one patient preferred to sleep on a mattress on the floor in Balcarres Ward, rather than board in an unfamiliar environment. We raised concerns over boarding arrangements with the CNM and SCN on the day of the visit. We were told that due to the current demand for beds across the hospital site, patients were regularly asked to board in other wards overnight. We were told that senior managers were aware of the negative impact boarding had on patients, however there had not been any progress in rectifying the situation.

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 continued to smoke to in the courtyard area. We also saw patients smoking in the corridor leading to the courtyard on the day of the visit. We heard from staff that the Covid-19 pandemic restrictions which were imposed on patients, increased smoking in the ward environment. NHS Lothian sought advice

from Public Health during the first Covid-19 lockdown to permit smoking in the courtyards, in order to prevent patients smoking in the ward environment, due to the associated risks. We heard that plans were in place to support a smoke free environment. A smoking cessation team had been employed, alongside a senior health promotion worker. They planned to review all of NHS Lothian's smoking policies and support their implementation.

The CNM, SCN and nursing staff told us they felt it would be difficult to change the current smoking arrangement, as patients were opposed to the plans to create a smoke free environment. Whilst we were sympathetic to this situation, smoke free legislation is in place and applies to all hospitals within NHS Scotland.

Recommendation 8:
Managers should address the outstanding environmental issues in relation to decoration, cleanliness and maintenance issues to make the environment more homely and therapeutic.

Recommendation 9:
Managers should consider returning the dedicated quite room in the ward to being a therapeutic and quiet space for patients.

Recommendation 10:
Managers should consider and review current boarding arrangements to ensure patient safety, welfare and well-being are prioritised.

Any other comments

Staff told us that the team in Balcarres ward were supportive of each other, creating a positive working environment. Staff praised the ward management team, reporting that they felt listened to and supported in their own development. We heard that there were monthly staff team meetings and one-to-one appraisals. There was additional support for newly qualified nurses provided by a clinical educator.

Although staff morale was generally good, we were told by staff that the ward had experienced staff shortages and there were nursing staff vacancies and staff sickness. Staff told us that working in a team that was short staffed on a regular basis was challenging, and has negatively impacted on their health and well-being. Staff reported that they felt the clinical patient acuity in Balcarres Ward had increased and the addition of flex and surplus beds left staff feeling that they were not always able to provide good quality nursing care and treatment, which left them feeling demoralised.

The CNM and SCN told us that there had been initiatives to support recruitment, such as modern apprenticeships that offered work experience, development of nursing skills and access to practical learning while studying. We were encouraged to hear about the ongoing recruitment initiatives, however managers should also prioritise support for current staff to promote staff wellbeing and retention of skilled nursing staff.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
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Recommendation 3:
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Recommendation 10:
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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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