Mental Welfare Commission for Scotland

Report on announced visit to:

Fairmile and Canaan Wards, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh EH10 5HF

Date of visit: 16 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.

Canaan and Fairmile Wards are dementia assessment units for older adults in Edinburgh. The wards have been based in purpose-built facilities in the new Royal Edinburgh Building since 2017. Canaan is a male ward and Fairmile is a female ward. Both were designed with 15 beds and provide single en-suite facilities for every patient.

We last visited this service on 31 May 2021 and made recommendations about improving clinical recording in the daily notes, the quality of care plans, legal authority for the treatment of detained patients and for managers to address the lack of lockable storage space in patient bedrooms.

On this visit we wanted to follow up on the previous recommendations and to find out about patient, carer and staff experiences, particularly on Canaan Ward, which had recently joined with Pentland Ward.

Who we met with

We met with and or reviewed the care and treatment of seven patients. We spoke with four carers/ relatives/ friends on the day and three following the visit.

We also spoke with the charge nurses and nursing staff on the wards and one of the psychiatrists.

Commission visitors

Dr Juliet Brock, medical officer

Gillian Gibson, nursing officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

At the time of our visit both wards were full. Patients appeared generally relaxed and there was a calm environment on both wards. We found that patients appeared well groomed and well presented.

Feedback that we received from carers, and from those patients that were able to talk with us, was overwhelmingly positive. One patient on Fairmile Ward told us "the staff are very attentive, you can always ask someone", whilst another remarked "the nurses are great, it's very friendly" You couldn't improve this place, it's great!" One patient did mention that the nursing staff were very busy.

Family members told us that staff took time to get to know the patients and respected their wishes. Relatives of patients on Canaan Ward described the staff as "fantastic" and "brilliant". On both wards families said there was good communication from the clinical team and they felt involved and consulted in their relatives' care. They also said there was good availability of medical staff and good monitoring and provision of physical health care.

Since our last visit there had been a significant change on Canaan Ward, with the amalgamation of Pentland Ward late in 2022. The closure of Pentland and transfer of staff and patients to Canaan Ward took place at short notice. We were advised the change was primarily due to staffing challenges across the service. Pentland was a ward for male patients with dementia who experienced significant behavioural difficulties and required a period of hospital based complex clinical care (HBCCC). As patients who were admitted to Pentland Ward were usually transferred there from Canaan, having been initially admitted and assessed there, there were established and effective working relationships between the teams. There was shared psychology and OT input; nursing staff often had periods of secondment between the wards to gain experience of both acute and continuing care for the patient group.

One family member of a patient from Canaan Ward told us their relative had been moved from Pentland Ward when it closed down. They said they had been given the opportunity to meet with senior managers prior to the move and that the transition had been smooth. They had no concerns about the change in their relative's care.

The relative of a patient recently discharged from Fairmile Ward told us "To be honest I think it was superb; the accommodation, the staff, everything was first class…I felt involved and couldn't have wished for better in supporting us with discharge".

We only received feedback that raised concerns from one patient and their spouse. This was in the context of a highly distressing admission from the community and disagreement about the need for hospital care. We discussed their concerns and recommended advocacy support.

Multidisciplinary team (MDT)

We continued to see a good level of multidisciplinary team (MDT) working on this visit, with patients receiving support from a range of professionals, including occupational therapy (OT), psychology, speech and language therapy and physiotherapy.

We were told there was good occupational therapy input to both wards, with OTs carrying out assessments, supporting patients with accessing equipment/aids and also assisting with activities and patient escorts.

Both wards continued to have a full time activity coordinator in post, although the co-ordinator on Fairmile Ward was on maternity leave at the time of our visit.

Clinical psychology support has also remained at a good level. We were told that the psychologist covering both wards was able to attend ward rounds, was involved in developing individual patient formulations and behavioural management plans and also continued to support staff training, including in the Newcastle Model for the management of stress and distressed behaviours.

We were advised that a pharmacist attends the weekly MDT meeting for both wards.

Referrals to physiotherapy, speech and language therapy and dietetics could be made on a case-by-case basis and we were told that response times for all three was prompt on receipt of the referral, with advice and support often available the same day or at most, in a few days.

We had been aware of significant nursing staffing challenges across the Royal Edinburgh Hospital (and more widely in other sites in NHS Lothian, and indeed across Scotland) over the past 12-18 months. Senior staff confirmed that Canaan and Fairmile Wards had been impacted by this. In addition to the unplanned closure of Pentland Ward, we were advised that agency staff were used to a high degree on both wards. This presented challenges to permanent staff on shift, as, for example, agency nurses were often not trained in using the electronic prescribing and medicines administration system, HEMPA. Senior nursing staff explained that these challenges had an impact on patient care and in the availability of time and resources available for quality improvement work on the wards.

Both wards have medical input from a consultant psychiatrist, specialty doctor and trainee doctors. Following the retirement of the former consultant psychiatrist there had been a period of temporary senior medical cover, however there has been a recent appointment to the permanent post.

Two social workers were due to join the older adult service on the week of our visit. It was hoped that these new posts would support better integration with social services in the community, supporting transition from hospital, particularly for individual patients whose discharge was delayed.

Care records

Almost all patient records were held on the electronic record system TRAK. Some information was only held in paper format, increasing the potential risk of relevant information being overlooked or lost.

We noted that there was variation in the quality of record keeping on both wards. Daily clinical care entries were mainly focussed on physical health and lacked detail regarding the mental wellbeing of individuals, or general descriptions of how they spent their day. For patients experiencing episodes of distress, there was variation in the recording of non-pharmacological approaches prior to the administration of as required (prn) medication.

There was some evidence of one-to-one meetings with staff, but we would have expected more. In the files we reviewed, we found that risk assessments were basic, with no evidence of review. In one case on Fairmile Ward we were unable to locate the patient's risk assessment.

We found good evidence OT support, with detailed assessment & recording of input, and the same for psychology input, with excellent individual formulations for patients.

There was good recording of MDT meetings, listing those present, summarising progress and identifying actions. Individual records also showed evidence of MDT discussions with family members.

Nursing care plans

The quality of the nursing care plans were variable. The patient records we reviewed on Fairmile Ward had basic care plans that were lacking in detail and meaningful content and we found little evidence of review. On Canaan Ward, most of the care plans we reviewed were person-centred and had a good level of detail, particularly in relation to physical health, however these also lacked robust review. We were unable to find care plans for one patient we reviewed on each of the wards.

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:
We repeat the following recommendation from our last visit: "Managers should review the quality of information recorded in daily entries to ensure this provides a meaningful narrative on individual patient's difficulties, progress and recovery. A regular audit programme of the care plan should be developed to ensure their quality."

Use of mental health and incapacity legislation

At the time of our visit, a number of patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). We found documentation and record keeping, in relation to the Mental Health Act, was of a good standard across both wards.

Many patients had in place either a power of attorney or guardianship under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). For patients who were subject to welfare guardianship or had a power of attorney, we found some paperwork was available online, whilst some was available in paper format.

Medication was prescribed electronically using the HEPMA system. We reviewed online prescribing and crosschecked the authorisation (on T2/T3 certificates) for patients receiving treatment under the Mental Health Act. Canaan Ward had a folder that contained copies of all T3s for ease of reference. This enabled easy checking of all legally authorised medication. Fairmile Ward did not have this, although we were pleased to find that all T3s were in order on both wards.

Where patients required section 47 consent to treatment certificates under the AWI Act, these were in place, although three out of four on Canaan Ward had no treatment plan accompanying them. We discussed this with staff on the day.

Patients receiving covert medication had an appropriate pathway in place, with evidence of pharmacy input, family involvement in discussion and review within appropriate timescales.

Recommendation 2:
Managers should ensure that where there are section 47 certificates in place, there is an accompanying treatment plans available to cover all relevant medical treatment that the individual is receiving.

Rights and restrictions

We were advised that both wards have a locked door policy, though we could not find information about this policy displayed outside the wards for visitors. It is important to ensure this is present.

Recommendation 3:
Managers should ensure that there is a clear policy in relation to the locked door and that this is easily accessible for all.

One relative commented on the importance and significance of their first visit to the ward and the experience of rooms and doors being locked.

We were pleased to note that there was an information booklet available for relatives on Canaan Ward and that Fairmile Ward were working to update their information for relatives. No support groups for carers were available at the time of our visit.

Visiting restrictions due to Covid-19 had eased since out last visit and we were pleased to note that visiting was mostly unrestricted. Relatives have been asked to advise staff in advance and to ensure that patient mealtimes remained protected, unless carer support at these times was indicated.

For detained patients, we were pleased to see that there was a letter from the RMO explaining their detention status, their rights and how to exercise them. Two patients on Canaan Ward had a curator ad litem appointed. We saw advocacy involvement recorded for only one of the patients whose care we reviewed. We were told that advocacy support was available on the hospital site from Advocard and referrals were made for individual support whenever this was needed.

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

Of those that we spoke with on Fairmile Ward, they mentioned activities such as craft, knitting and music groups. On Canaan ward the activity board was sparse, with the exception of pet therapy and music therapy.

A few relatives spoke of a lack of activities or being unsure if activities were taking place and thought their relative might be bored. There was limited reference in the notes we reviewed relating to participation in activities. Although OT assessments were detailed, and the importance of meaningful activity was identified in care plans, we found limited evidence that activity was taking place, other than that recorded by the OT, or where nursing staff reported that the patient had watched television. The senior charge nurse told us that the activity co-ordinators do not record in patient files.

Staff told us about pet therapy, music therapy and fortnightly visits by a chamber music group, and that the wards had access to Playlist for Life. There were plans to improve activities, and by introducing art therapy, and in particular, optimising music therapy, which was enjoyed by patients across both wards.

Unfortunately, group outings had not been possible due to staffing levels. In the past the wards organised bus trips, including to a regular dance at a local miners club. We were told that where possible, members of the wider clinical team were supporting ward staff to take patients out on an individual basis. Families were also being encouraged to take their relative out where this was safe and appropriate.

On the general hospital site, facilities such as the Hive Centre and the Cyrenians Community Garden had reopened and were available for access.

Recommendation 4:
Managers should look at ways to improve the recording of activities in clinical patient records.

The physical environment

Patients and carers spoke positively about the environment on both wards. Family members on Canaan Ward commented that the ward was clean and they liked the garden. On Fairmile Ward the same was said, with one patient commenting “It’s really quite luxurious having your bedroom and your own bathroom to hand”.

All bedrooms were en-suite. Four of the fifteen bedrooms on each ward were fitted with an alarm system to detect falls, and to support falls prevention for patients who were vulnerable to this. We were told that a section of one bedroom corridor on Fairmile Ward could also be ‘locked off’ for use by patients on the adjoining Canaan Ward if required, enabling four ‘swing beds’ to be transferred for male use if needed.

Bedrooms were large and comfortable and patients were able to personalise them with photos and personal items. On Fairmile Ward, the whiteboard in patient rooms was personalised with a ‘what’s important to me’ list, based on information shared by family from the person’s Getting to Know Me document. Although we highlighted this good practice on Canaan Ward on our last visit, we did not see this evidenced in the rooms we viewed on this visit, which seemed a missed opportunity.

On the last visit we highlighted concerns about patients on Canaan Ward not being able to store clothes in their room and made a recommendation to address this. The action plan received from the service advised that a solution was being devised with contractors. On this visit we were told that it was not possible to have doors on patient cupboards, so the majority of patient clothes on Canaan Ward were still stored in the clothes bank, with a small number of items being rotated to the person's room based on their preference. We heard from relatives about clothing going missing, or their relative wearing other patients' clothes. It appears this is an area of care that continues to require improvement.

The communal areas on both wards were clean and bright, with pleasant outdoor space in the private courtyard areas easily accessed through the patient lounge.

We felt that the décor on both wards was looking a little tired in places and would benefit from a refresh, particularly in the main communal area on Fairmile Ward. There was also a defect in the flooring in the corridor on Fairmile Ward which presented a significant trip hazard. This had been temporarily fixed using tape. We were advised that professional repair was awaited by the estates department.

Some areas on both wards remained rather clinical, stark and lacking in interest. Examples included the corridors on Canaan Ward and the lounge in Fairmile Ward, where the large display shelving unit dividing the space was empty at the time of our visit.

The therapy rooms on both wards appeared well equipped and the quiet rooms, separate from the main lounge/dining spaces, were said to be well used by patients.

The outdoor garden space on both wards was well kept and well used, offering plenty of seating and areas of interest, such as raised beds or outdoor games, to walk around. We were told about volunteers visiting the ward and helping in the garden with planting bulbs.

Any other comments

At the time of this visit we were advised of a number of delayed discharges and heard that delays were primarily due to waiting for welfare guardianship applications to progress through court and for nursing home placements. Although patients were usually referred to social work in a few weeks of admission, sometimes social work did not become involved until the patient became a delayed discharge. Weekly 'delayed discharge hub' meetings have continued to take place, with patients from across older people's services being discussed, to alert and help progress individual cases. It is hoped that the newly appointed social workers may help liaise with community services in these cases to support the discharge process where possible.

Summary of recommendations

Recommendation 1:
We repeat the following recommendation from our last visit: "Managers should review the quality of information recorded in daily entries to ensure this provides a meaningful narrative on individual patient's difficulties, progress and recovery. A regular audit programme of the care plan should be developed to ensure their quality."

Recommendation 2:
Managers should ensure that where there are section 47 certificates in place, there is an accompanying treatment plans available to cover all relevant medical treatment that the individual is receiving.

Recommendation 3:
Managers should ensure that there is a clear policy in relation to the locked door and that this is easily accessible for all.

Recommendation 4:
Managers should look at ways to improve the recording of activities in clinical patient records.

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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