Mental Welfare Commission for Scotland

Report on announced visit to:

Hermitage Ward, Royal Edinburgh Hospital, Edinburgh, EH10 5HP

Date of visit: 14 August 2023

Where we visited

Hermitage Ward is the adult acute admission ward for male and female patients residing in the East and Mid Lothian areas of NHS Lothian. We heard that the majority of beds were used by East and Mid Lothian patients. However, some of the beds were occupied by City of Edinburgh patients for a variety of reasons. This could mainly be due to bed capacity across the hospital site, patients from East and Mid Lothian who chose not to be an inpatient in Hermitage Ward due to it being mixed-sex ward and/or resulting from risk assessment of a patient's suitability for a mixed-sex ward.

Hermitage ward has 16 beds for both male and female patients. On the day of our visit there were 17 patients in the ward. One of the quiet rooms that had a contingency bed was being used as a bedroom.

We last visited this service on 17 December 2020 and made recommendations in relation to the service reviewing responsible medical officer (RMO) contact arrangements for East and Mid Lothian patients and adults with incapacity (AWI) training for staff. Our report in 2020 raised concerns that East and Mid Lothian patients did not have as regular contact with their RMO as City of Edinburgh patients. We were pleased to be told by staff and patients that there was regular contact, review and multidisciplinary team (MDT) meetings between patients and RMOs from all geographical areas.

On the day of this visit, we wanted to meet with patients and relatives/carers to hear how care and treatment was being provided on the ward and also follow up on the previous recommendations.

Who we met with

We met with, and reviewed the care of seven patients, six who we met with in person and reviewed the care notes of. We also spoke with two relatives.

We spoke with the clinical nurse manager (CNM), senior charge nurse (SCN), charge nurse (CN), nursing staff, clinical psychologist, and occupational therapist (OT). Following the visit, we made contact with the music therapist and mental health officer (MHO) social work teams from East and Mid Lothian.

Commission visitors

Kathleen Liddell, social work officer

Alyson Paterson, social work officer

Denise McLellan, nursing officer

What people told us and what we found

Care, treatment, support, and participation

Comments from patients and relatives/carers

The patients we met on the day of the visit were mainly positive about their care and treatment in Hermitage Ward. The feedback included comments such as, “staff are fantastic”, “I feel my views are listened too”, and “I like to attend the ward rounds as I feel involved in my care and treatment”. Some patients told us that they had a named nurse who they met with regularly and valued this one-to-one interaction. Other patients were unaware of who their named nurse was.

The majority of patients told us that they had regular reviews with their RMO and were invited to attend their weekly MDT meeting, commenting that this was a positive experience. Some patients reported that they chose not to attend the meeting.

A few of the patients told us that they had been involved in the compilation of their care plan and had a copy of it. Other patients we spoke to were unaware they had a care plan. Some patients were aware of discharge planning and others were unaware of any discharge plans.

All of the patients we spoke to commented that staff were extremely busy and were aware of staffing pressures. Patients reported that at times they felt they could not approach staff if they needed to talk, however they added that this was due to the pressures on staff and not an unwillingness from staff to spend time with patients. Some patients raised that they did not like it when bank and agency staff were used, as these staff members did not know them or their care needs well and it could make them feel unsettled and unsafe.

Patients told us that they liked their rooms, and most patients liked the food. Many of the patients commented positively about the housekeeper and the good rapport they had with these members of the team. The patients commented on how clean the ward was and how they benefitted from the additional support the housekeeper offered to them, mainly engaging in arts and crafts with patients.

All the patients we met with told us that the communal area in the ward could be loud at times and felt this could raise their own levels of stress and distress. Patients added that there was a lack of quiet space in the ward for them to use out with their bedroom area.

The main issue of concern raised by patients was the lack of activity in the ward. Patients told us that there was nothing to do, that they felt bored and had no structure to their day.

We spoke with two relatives/carers who provided positive feedback about nursing staff, reporting that staff were approachable and took time to talk to relatives/carers when requested. One relative/carer felt that more frequent communication with the consultant psychiatrist would be beneficial and supportive. One relative/carer was not aware of the MDT meetings and would have liked the opportunity to attend, as they didn’t always feel they were part of decision-making. The relatives/carers commented on how busy staff were on the ward because of the staff shortages, which could result in concerns that the member of their family was not always getting consistent care.

Care plans

Care plans are a tool which identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. Care plans should be regularly reviewed to provide a record of progress being made.

We found the care plans in Hermitage Ward to be of mixed quality. We were pleased to find that some of the care plans were individualised, person-centred, evidenced strengths-based, goal or outcomes focussed interventions. These care plans included information on what and who was important to patients, how the patients preferred to be communicated with and supported by staff, and what interventions did not support them. Some of the patients we met with had a copy of their care plan and told us they had actively participated in the compilation and review of their care plan. Other care plans we reviewed did not have the same level of detail, with little evidence of personalised care or clear detail on the purpose of the nursing intervention recorded. For example, we found many care plans that recorded an intervention to support the patient such as, 'use of distraction techniques' however, the care plans lacked detail as to what was involved in that specific intervention.

We found some evidence of relative/carer involvement in the care plans we reviewed. Some of the patients we met with were clear that they did not want their families involved in their care plan. We found that where appropriate, families had had some involvement in the care plan and had provided information from their perspective as a relative/carer.

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. We found referrals being made to services such as physiotherapy, dental clinic, and speech and language therapy where appropriate.

We found that care plans were reviewed regularly. The quality of the review process was mixed. We found some excellent examples of patient reviews that evidenced robust information including summative evaluation regarding efficacy of intervention, targeted nursing intervention, as well as the individuals' progress. These reviews included detailed discharge planning and discussion with community teams to support discharge. Other reviews did not include this level of information therefore making it difficult to evidence if the patient was making progress towards their admission aims, objectives, and care goals.

We discussed the variable quality of the care plans and the accompanying reviews with the CNM and SCN on the day of the visit; we were told that they were aware that ongoing improvements were required in relation to care planning and reviews. The care plans in Hermitage ward were regularly audited by other SCNs in the Royal Edinburgh Hospital (REH). However, given the Commission feedback, the CNM and SCN agreed that an audit of the care plans by the SCN in Hermitage Ward would be beneficial 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

Care records

Information on patients care and treatment was held electronically on TrakCare. We found this easy to navigate.

It was evident from reviewing the care records that there were high levels of acute mental health issues for the patients in the ward. The patient group could experience significant levels of stress and distress, leading to increased clinical risk due to increased levels of verbal and/or physical aggression, and self-harm. We were pleased to note that the MDT were actively involved in providing the support, care, and treatment to patients at these times.

The information recorded in care records was also of variable quality. We found examples of care records that provided detailed and personalised information which included what the patient had achieved and aspects of the day that had been difficult. Other care records did not record this level of personalised information and used language such as 'evident on the ward'. This use of language did not provide information on the patient's current issues or staffing interventions. We would have preferred to have seen care records that were person-centred and detailed personalised information. We saw evidence of one-to-one interventions between nursing staff and patients. We noted that many of the one-to-one interventions were initiated by patients. Patients told us that due to staff shortages and workload pressures, they often had to ask for this level of support.

We were pleased to see comprehensive care recordings from various members of the MDT. The care records from the music therapist and OT 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 noted that some staff used pre-populated headings that were regularly used in other wards in the hospital, and other staff used free text to record care records. We found that the care records recorded on the pre-populated headings were more detailed, personalised, and intervention focussed. We discussed with the CNM and SCN the contrast in the care records that we had reviewed and were told that a decision had been made by the clinical team to move away from the pre-populated headings as some headings were not relevant to the patient group in Hermitage Ward. The SCN told us that there was an expectation that nursing staff would focus on the patient's mental state and record how this has impacted on their day. Given the feedback from the Commission, the SCN agreed that an audit of the care records was required to ensure consistency in the quality for all patients.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based in Hermitage Ward, or accessible to them. In addition to nursing staff, there were consultant psychiatrists, a psychologist, an occupational therapist, a recreational nurse, junior doctors, and a music therapist. The structure of the MDT in Hermitage Ward differs from the other acute wards in the REH, as it

covers two Health and Social Care Partnerships (HSCP) as well as City of Edinburgh patients. Mid and East Lothian had two RMOs for each HSPC, each RMO held weekly MDT meetings. City of Edinburgh RMOs also held weekly ward rounds and we heard that there could be up to seven RMOs and MDT meetings occurring in the ward on a weekly basis. We were told that it was impossible for the full MDT to attend all of the weekly MDT meetings. There was an arrangement in place that staff would prioritise what MDT meetings they needed to attend, usually based on MDT discussion and decisions made at the daily huddle. On reviewing the patient files, we saw that generally the RMO, nursing staff, and psychology, attended most of the MDT meetings. We also saw meetings where the full MDT had attended when decisions in relation to risk, future planning, and discharge were taking place.

We saw evidence of detailed psychology formulations in some of the patient files we reviewed. We met with the psychologist who advised that psychology input was part-time in Hermitage Ward and there was not sufficient capacity to complete formulations for all patients. Ideally, psychology would have capacity to have one-to-one interventions with all patients who required it and additionally, run groups that would be beneficial to patients in acute wards, such as mindfulness, cognitive behavioural therapy, and compassionate friend groups. On the day of the visit, we were told that the majority of psychology time was used for psychological first aid for staff, given the complexity and acuity of the mental health needs of the patient group. We were pleased to hear that additional psychological resource was being recruited.

The MDT meeting was recorded on TrakCare, on a template with pre-populated headings relevant to the care and treatment of the patients. We found detailed recording of the MDT discussion, decisions, and personalised care planning for the patients. There was evidence of discharge planning for some of the patients we reviewed. For these patients, there had been communication with community teams to support discharge planning. In addition to MDT meetings, we were pleased to find that that Care Programme Approach (CPA) was used for at least one patient. CPA is an approach used in some mental health services, such as forensic settings to assess needs and then plan, implement, and evaluate the patient's care in a robust, comprehensive way.

Patients were invited to attend their MDT meeting and we were told by most patients that they found the meetings positive, as they are able to provide their views about their care and treatment. The relatives/carers we spoke to told us that they were unaware of the MDT meetings and would like the opportunity to attend if appropriate. We discussed this with the SCN who advised that relatives/carers were welcome to attend MDT's if appropriate, and agreed to discuss with staff that patients should be made aware that they could invite their relatives/carers to MDT meetings if they wished.

We contacted the East and Mid Lothian social work (SW) and mental health officer teams for feedback on their experience of engagement with Hermitage Ward. We were pleased to hear that there were positive working relationships between the services. SW were invited to attend MDT and CPA meetings, and reported good care and treatment offered to the patients they worked with. SW commented on the work pressures on nursing staff and the impact this has had on communication.

Use of mental health and incapacity legislation

On the day of our visit, 13 of the 17 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. On reviewing the electronic files, we found that one patient did not have a valid T2 certificate authorising treatment. We raised this with the CNM and SCN on the day of the visit and requested an urgent review of the patient's consent to treatment was undertaken. We also 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) Act 2000 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. No s47 forms were required on the day of the visit.

One of the patient files we reviewed had Adult Support and Protection (Scotland) Act 2007 (ASP Act) concerns recorded. We were pleased to see that ASP Act concerns had been identified by the clinical team and reported to SW. An ASP Act case conference had been progressed and the recording of this meeting evidenced full MDT discussion, risk assessment, and decision making to facilitate patient support and reduction of the identified harm.

Rights and restrictions

Hermitage Ward continued to operate a locked door, commensurate with the level of risk identified in the patient group. We were told that there was a locked door policy however, this was not on display at the door for patients and relatives/carers to refer to. The SCN agreed to ensure that this policy was placed at the door.

We noted some information on rights located on the ward notice board and copies of the Commission's *Rights in Mind* booklets in the communal areas. We were pleased to see 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, not all of the patients that we met with had a clear understanding of their rights and detained status. On review of the patient files, we did not find records of ongoing discussion regarding rights. This concerned us and we would have preferred a more proactive approach to rights-based care being offered to patients in Hermitage 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, such as weekly discussion at the MDT meetings with patients regarding their legal status and associated rights.

On reviewing patient files, we looked for copies of advance statements. The term advance statement refers to written statements made under sections 274 and 276 of the Mental Health Act, and an advance statement 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 these. We found one advance statement in the patient files we reviewed. Some of the patients we spoke to were aware of advance statements, however had chosen not to complete one, and other patients were unaware of them. It was evident from 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 future 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.

We were told that patient advocacy was provided regularly in the ward by advocacy services from each HSPC. We were told that advocacy attend the ward on request and provide a good service to patients who wish to engage with them. We were pleased that all of the patients we met with on the day of the visit either had or had been offered advocacy support.

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 1:
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

The activities in Hermitage Ward were provided by a recreational nurse. On the day of the visit, we were told that the recreational nurse had been on leave for a period of time. We were told that alternative staff cover for this role had been arranged given the importance of structured activity in an acute ward setting. Unfortunately, this staff member was also on leave. As a result, the level of activities available for patients in the ward was extremely limited and patients raised this as an issue, reporting that they had no structure to their day and often felt bored. The lack of consistent and structured activity was also evident in the patient notes we reviewed.

We were pleased to hear that there were some opportunities for patients to engage in activity. The OT held a weekly coffee morning in the ward which was well attended. The OT told us that

the coffee morning provided an opportunity and space for patients to meet with staff and give feedback on any ward issues. We heard that it was a regular theme that patients were requesting more ward-based activities. We were told by staff and patients that the housekeeper was key in providing opportunities for patients to engage in activities, mainly arts and crafts. We were able to see some of the artwork patients had completed with the support of the housekeeper. Patients and staff spoke highly of this support.

Music therapy was offered as a group session and on a one-to-one basis on a weekly basis by the music therapist in Hermitage Ward. For the patients who attended music therapy, we noted that the recording of the session in their care records was of a high standard, recording personalised and comprehensive information, and providing detail on the purpose of the intervention.

The information board in the ward provided details of activities that took place at The Hive. The Hive is a day service run by the Scottish Association for Mental Health (SAMH), and is situated in the grounds of the REH that offers a variety of activities and groups. Patients could attend The Hive, although this was dependent on risk assessment and pass time permitted off the ward.

We discussed the lack of activity with the CNM and SCN. We were pleased to hear that some initiatives had been proposed to offer more activity in the ward, such as a referral for a therapet and a recently granted application for a table tennis table for the ward. Nevertheless, we would expect the patients to have access to regular activities to maximise therapeutic benefits, improve mental well-being, increase social interactions, and reduce stress and distress.

Recommendation 2:
Managers should ensure that there are structured activities regularly available to patients that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

The physical environment

Hermitage Ward was the only mixed-sex admission ward in REH, therefore the physical environment had to be managed differently from other admission wards in the hospital to support patients to feel safe and comfortable in the ward setting. The bedroom space in the ward was divided into a male and female area. Each bedroom had en-suite facilities and we heard and saw that patients can personalise their room if they choose to.

On the day of the visit, we saw that there was a male patient in the female area of the ward, due to bed pressures. We were told that a comprehensive risk assessment had been completed and that staff were observing the area closely. Patients did not raise this as an issue on the day of the visit, however, we were concerned that this arrangement/practice had potential associated risk factors for male and female patients, especially given the known staffing pressures on the ward.

The cleanliness of the ward was of a high standard. The ward had a range of spaces available for patients to use. The main space used by patients and staff was the communal TV/dining area which was open plan. On the day of the visit, this area was calm and settled however,

many of the patients we spoke to told us that this area can become loud at times, which some patients found anxiety-provoking.

We saw one of the quiet rooms and a space in the female area of the ward that had soft seating next to a large window and some artwork. This area offered a therapeutic and quiet space for patients.

We had concerns over the use of one of the quiet rooms in the ward. On the day of the visit, one of the quiet rooms had a surplus bed that was being used by a male patient as a bedroom. The room did not have washing or toilet facilities, compromising the patient's right to privacy and dignity. We were told that the quiet room was used regularly as a bedroom and was not available for patients to use as a quiet room. Although we are aware that at times there has been a national shortage of mental health beds, we did not consider this room appropriate or safe to use as a patient bedroom. Furthermore, we were concerned that by using this space as a bedroom, it limited the therapeutic and quiet space available on the ward for patients to use. We were told by some patients that the ward environment was often busy and loud, and it was difficult to find quieter areas in the ward. We would suggest that patients would benefit from having a quiet and therapeutic space to use.

There was a large courtyard garden area that was easy for patients to access. Patients could access the garden area from 6am until midnight. We saw during the visit that this area of the ward was regularly used by patients.

Recommendation 3:
Managers should consider returning the dedicated quiet room in the ward to a therapeutic and quiet space for patients.

Any other comments

We heard from patients and staff that there were staff shortages on the ward which could negatively impact on patient care. Staff were extremely busy and felt they didn't always have as much time as they would have liked to spend with patients, in order to build a more therapeutic relationship. We heard that the complexity and acuity of the mental health of the patient group had increased, which had been difficult for staff to manage. However, we were pleased to hear that staff felt supported by the management team and benefitted from regular input from psychology staff as well as attending reflective practice sessions.

We heard and saw evidence of good leadership in Hermitage Ward. Every staff member we spoke to told us that they felt supported by the SCN. The staff told us that there was a clear ward ethos relating to providing high standards of care to patients. It was evident from speaking with patients and from reviewing the files, that the influence of the SCN was reflected across the whole clinical team, who had adopted a compassionate and caring approach to the patients. We found the leadership team to be committed to the patients and staff, transparent about areas of progress required in the ward, and driven to achieve identified areas of improvement. We were pleased to see that the team morale continued to be positive, even although the ward had experienced some challenges in previous months.

Summary of recommendations

Recommendation 1:
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.

Recommendation 2:
Managers should ensure that there are structured activities regularly available to patients that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

Recommendation 3:
Managers should consider returning the dedicated quiet room in the ward to a therapeutic and quiet space for patients.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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