Mental Welfare Commission for Scotland

Report on announced visit to: Braids Ward, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 4 December 2023

Where we visited

Braids Ward, formally known as Ward 13 and Roseburn Ward was last visited in January 2020. Since this time, Braids Ward has moved to the new part of the Royal Edinburgh Hospital.

Braids Ward is a 15-bedded, mixed-sex ward that provides care to adult acute inpatients between the ages of 18-65 years old. The ward predominantly focuses on complex discharges which are assessed through the referral system on transfer to the ward. The overall ward dynamic is a mixture of both physical and mental health diagnosis which is managed by the multidisciplinary team (MDT). This helps to support the individual's overall recovery pathway, promoting the best interests of all those involved.

We heard and saw that some of discharges have been delayed due to several factors, including issues with community care and housing provision.

When we last visited Ward 13, we made recommendations in relation to the MDT, care goals, the authorisation of medical treatment and activities. On the day of this visit we wanted to follow up on the previous recommendations and meet with individuals, relatives, carers and staff and look at the care and treatment being provided on the ward.

Who we met with

We met with, and reviewed the care of seven individuals, five who we met with in person and seven who we reviewed the care notes of. We also spoke with one relative.

We spoke with the clinical service manager, the senior charge nurse (SCN), nursing and occupational therapy staff. We also made contact with Volunteer HUB.

Commission visitors

Kathleen Liddell, social work officer

Dr Juliet Brock, medical officer

What people told us and what we found

The individuals we met on the day of the visit were positive about their care and treatment in Braids Ward. The feedback included comments such as, “Braids is the best ward I have ever been in”, “staff are helpful and kind” and “my cooking skills have developed a lot since being in Braids”.

All of the individuals told us that they had a named nurse, who they met with regularly, and valued this one-to-one interaction. Individuals we met with reported that all staff made time to spend with them on a daily basis. Most of whom we met with reported that the ward environment was relaxed and they felt safe in the ward.

One individual raised that they would have liked the option to attend the weekly MDT meeting. Other individuals were happy with the current arrangement, that they do not attend the meeting. We discussed with the SCN that in order to promote the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), individuals should be given the choice as to whether they choose to attend the meeting. The SCN agreed to discuss with the MDT and support attendance for individuals who wanted to attend.

Most of the individuals we met with were aware of their care plan, adding that they had been involved in the compilation of it. Most told us that they felt involved in discussion and decision-making regarding their care and treatment. Individuals we met with told us that they liked the regular contact with advocacy services and contact with the patient council, based in the Royal Edinburgh Hospital.

Some of the individuals we met with spoke positively about the activities in ward, especially the visits from the therapy dog.

We had a discussion with one relative/carer. Although the carer/relative raised some issues with aspects of their loved one’s care plan, we were told that they felt able to discuss their concerns with the nursing staff. They told us that they did not always feel involved in decision-making and would have liked to have the option of having more contact with the consultant psychiatrist. We heard that they had attended a discharge planning meeting and found this meeting beneficial and supportive. We heard that the relative/carer found staff “very friendly and offered good care”.

Staff we met with told us that the team in Braids Ward were supportive of each other, creating a positive working environment. Staff told us that the team had expanded and developed since the previous visit and there was a good skill mix of more experienced and newer qualified staff. We were pleased to hear that staff retention was high and although the ward was not fully staffed, there were only a few vacancies therefore the need to use bank staff was minimal.

Staff also praised the ward management team reporting they felt listened to and supported to develop their skills, especially in relation to physical health which supported holistic care for individuals in Braids Ward. We heard that many staff had been supported to complete HNC and Open University courses.

The SCN told us that staff had the option to attend reflective practice sessions arranged by art therapy. In addition, staff were offered clinical supervision and encouraged to use this support.

Care records

Information on care and treatment was held electronically on TrakCare. We found this easy to navigate. The majority of care records were recorded on canned text, a pre-populated template with headings relevant to the care and treatment of the individuals in Braids Ward. It was evident from reviewing the care records that individuals had a diverse range of care and treatment needs. We saw that for many, they had complex physical health needs. We were pleased to see regular reviews of physical health care from medical staff and referrals to other services such as physiotherapy, where required. We saw that some individuals required high levels of support and or motivation with activities of daily living. We were pleased to see the range of nursing skills offered on the ward to meet the complex physical and mental needs of the individuals.

The majority of the care records we reviewed were of good quality, personalised, and evidenced a person-centred, strengths-based approach. The care records detailed what activities the individual had participated in that day, their level of engagement and any challenging and/or positive aspects of the day. We were pleased to see comprehensive recording from all members of the MDT. The care records from OT, medical staff, physiotherapy, and music therapist were personalised, outcome and goal focussed, and included forward planning. Most of the care records were of a high quality and evidenced the holistic approach offered to the individuals in Braids Ward.

There was evidence of one-to-one interactions between individuals and nursing staff. Some of the individuals we met with told us that they met with their named nurse regularly. The one-to-one interactions we reviewed were comprehensive and personalised. Some individuals we met with told us that they did not see their consultant psychiatrist regularly. We discussed this with the SCN on the day of the visit and were told that the referral criteria for admission to Braids Ward included individuals who did not require a high level of consultant psychiatrist input, given the limited consultant psychiatry sessions that the ward provided. However, individuals could request to meet the consultant psychiatrist if they wished.

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

We found the risk assessments to be of a high standard and included protective factors and a safety plan. The risk assessments were reviewed regularly and updated to reflect changes in the risk assessment. We found that for some individuals, risks had reduced, and we saw examples of positive risk-taking that supported progress in the individual's care plan. For others, we found that some risk factors had increased. In these circumstances, we found that the risk assessment had been amended to reflect the increased support required.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress that has been made.

Most of the files we reviewed included a comprehensive assessment that had been completed by nursing staff along with the individual, shortly after admission. The information recorded in the assessment was personalised and provided a good summary of key issues, care goals, and identified needs. We found the assessment to be holistic with information from all key professionals and relatives/carers included. We were pleased to see participation from the individual. For individuals who were unable to engage in the comprehensive assessment, documents such as 'Getting to Know Me' were used to promote participation and person-centred care.

We found some evidence of relative/carer involvement in the care plans we reviewed. Some of the individuals 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 care planning and had provided information from their perspective as a relative/carer to the individual.

We made a recommendation in the previous report in relation to reviews, including the evaluation of care goals. We were pleased to see the care plans were reviewed on a regular basis and we found evidence of meaningful review, detailing progress as well as aspects of care that required additional support following review.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a part-time consultant psychiatrist, a clinical fellow, a music therapist, a recreational nurse, an OT and an OT assistant. There was also access to physiotherapy, dietician, spiritual care, phlebotomy, social work, and psychology. Together, the MDT had an extensive range of knowledge and experience in completing complex discharges in a robust and safe way.

The MDT meeting was held weekly in the ward. In attendance at the meeting were medical staff, nursing staff and at times music therapy. The MDT meeting was recorded on TrakCare on a mental health structured MDT meeting template. We found there to be mainly comprehensive and detailed recording of the MDT discussion, with clear action plans that promoted a holistic approach to the individual's care. There was evidence of discharge planning for some of the individuals we reviewed. For these individuals, there had been communication with community teams and services to support discharge planning.

When reviewing the MDT meeting records, we found that many of the actions were for social work staff, who generally did not attend the meetings. We discussed with the clinical service manager and SCN that the inclusion of a dedicated social worker in the MDT would provide value, given the remit of the ward was complex discharge. We were told that having a dedicated social worker as part of the MDT was being considered. We heard that in order to promote regular communication with the MDT, a daily huddle meeting had recently been

introduced which social work locality managers attended. We were told that this had been positive in highlighting individuals who required a social work assessment to support discharge.

It was evident from reviewing the MDT records, and from discussions with individuals, that they did not attend the meeting. We were told that nursing staff met with the individuals on a one-to-one prior to and following the meeting, to discuss their care plan, ascertain their view and to discuss the outcome of the meeting and any decisions that had been made. However, we found inconsistent recording of discussions with individuals. Feedback from individuals we met with was mixed, with some stating that they would like to either attend or have the option of attending the meeting. Some individuals raised that they did not feel involved in decisions and discussions regarding their care and treatment; others were happy with the current arrangement. On the day of the visit, we discussed with the SCN that the MDT should review the current arrangements in order to promote and support greater participation at the MDT meeting.

In relation to carer/relative involvement, we heard and saw that when family were involved with their relative's care, and they were invited to attend discharge meetings.

Use of mental health and incapacity legislation

On the day of our visit, nine of the 15 individuals in the ward were detained under the Mental Health Act.

Part 16 (sections 235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments (such as artificial nutrition) and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 certificate if the individual is consenting.

Medication was recorded on the hospital electronic prescription management application (HEPMA). T2 and T3 certificates authorising treatment were stored separately on TrakCare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the accuracy for checking the correct legal authority is in place when prescribing or dispensing medication for those who are detained. For this reason, we suggested to the ward that a paper copy of all T2 and T3 certificates be kept in the ward dispensary, so that nursing and medical staff have easy access to, and an opportunity to review all T2 and T3 certificates.

On cross-checking each electronic record, we found that some detained individuals were prescribed treatment that was not authorised on a T2 or T3 certificate. We provided details of the individuals to the responsible medical officer (RMO) and requested urgent review.

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 (the AWI 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. From the files we reviewed, we were unable to locate a s47 certificate in one file and found that a s47 certificate that had been completed, did not have an accompanying treatment plan. We raised this with the SCN on the day of the visit.

Recommendation 1:
Managers and RMOs must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment, and that an audit system is put in place to monitor compliance.

Recommendation 2:
Managers and RMOs must ensure individuals who lack capacity in relation to medical treatment have section 47 certificates and where necessary, treatment plans completed in accordance with the AWI Code of Practice (third ed.), to cover all relevant medical treatment the individual is receiving.

Rights and restrictions

Braids Ward operated a locked door, commensurate with the level of risk identified with the individual group.

The individuals we met with during our visit had a mixed understanding of their rights and detained status, where they were subject to detention under the Mental Health Act. Most of the individuals we met with were aware of their right to advocacy support and we saw from care records that many individuals had met with advocacy and some had legal representation. We were pleased to see information on rights displayed in the ward's communal sitting area and a letter had been sent to the individual by the RMO, detailing their legal status and their rights in relation to this, and contact numbers for advocacy to support individuals to exercise their rights. We discussed with the SCN that given the individuals we met with had a mixed understanding of their detained status and rights, the MDT should consider ways to increase awareness and promotion of rights. We suggested contacting other NHS Lothian services areas who used a 'rights read' care record to record discussions with individuals regarding rights.

Individuals we met with told us that there was a community meeting in the ward every week, organised by nursing and OT staff. The meeting was an opportunity for individuals to communicate their views on any issues in the ward and discuss these with each other and staff. A minute was taken of the community meetings, and we were able to review some of these; we saw that one issue which was raised by individuals was in relation to the lack of information on named nurses. We were pleased to see that action had been taken and this information was displayed in the individual's room. We were pleased to see that advocacy had recently attended the community meeting and that the Royal Edinburgh patient council attended the ward regularly.

When we are reviewing individual files, we look 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 is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting

advance statements. One of the individuals we met had an advance statement. Others that we met with told us that they had chosen not to complete an advance statement and for some, it was evident from discussions with them that they did not have the level of capacity required to make a valid advance statement. The Commission's good practice guidance on advance statements is clear that the person making an advance statement, must have the 'capacity of properly intending' the wishes specified in it.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We heard and found evidence of a broad range of activities that were available for individuals in Braids Ward. The activity and occupation in the ward was mainly provided by the recreational nurse. On the day of the visit, we were told that the recreational nurse was not at work and activity was being provided by nursing staff, the music therapist, OT's and volunteers. We saw that nursing staff regularly offered and encouraged individuals to engage in activity.

There was an activities board situated in the communal area of the ward; this displayed the weekly timetable of activities on offer. The activities available included many festive-themed activities and opportunities for individuals to attend Christmas fayres, carol concerts, and arts and crafts groups. In addition, music therapy, music jam, a therapet session, pool tournament, male and female physiotherapy group, quizzes, board games, clay modelling, and attending the library were also available. We heard that some individuals attended the HIVE day service, which was an activity centre situated in the grounds of the hospital.

We met with an OT on the day of the visit, who told us that OT staff offered a range of group and individual interventions to people in Braids Ward, including activity that supported skill development. One of the individuals we met with commented that the OT support with cooking had been very beneficial. The OT told us about a new initiative that involved them working across acute services in the hospital site and arranging groups, including pottery, a creative group and a brunch group.

The physical environment

Braids Ward is mixed-sex, therefore the physical environment has to be managed differently from other single sex wards in the hospital, to ensure that individuals 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 observed that individuals could personalise their room if they chose to.

The cleanliness of the ward was of a high standard. The open plan communal TV/dining area was the main space used by individuals. The communal area had artwork and Christmas decorations displayed which promoted a homely and welcoming environment. We were impressed by the art mural leading to the communal area which had been completed by the individuals and the recreational nurse. The individuals were able to use the kitchen facilities

to make a hot drink and snack and had access to the outside courtyard from the communal area.

We also saw the therapy kitchen and laundry room that individuals could use, if appropriate, to support developing skills.

The ward environment was calm, welcoming, and settled on the day of the visit, with most of the individuals and staff using the communal area to engage in crafts, board games, and having a cup of tea and a chat.

We noted that some of rooms in the ward, particularly the quiet room which was used by individuals when who may feel overstimulated in the communal area, required some improvement to create a more therapeutic space. We raised this with the SCN who advised that there was a plan for ongoing environmental improvements.

There was a courtyard garden area that was easy for individuals to access. We heard that there were plans to develop a gardening group and use some of the garden space for planters and raised beds, which will support a more therapeutic garden area. We saw that there was a birdfeeder in the courtyard that some of the individuals enjoyed and also a basketball hoop that many of them used.

Summary of recommendations

Recommendation 1:
Managers and RMOs must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment, and that an audit system is put in place to monitor compliance.

Recommendation 2:
Managers and RMOs must ensure individuals who lack capacity in relation to medical treatment have section 47 certificates and where necessary, treatment plans completed in accordance with the AWI Code of Practice (third ed.), to cover all relevant medical treatment the individual is receiving.

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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