Mental Welfare Commission for Scotland

Report on an unannounced visit to:

Craiglockhart Ward, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 5 February 2024

Where we visited

Craiglockhart is a 16-bedded, female only, adult acute admission ward with a catchment area that includes the northwest and east areas of NHS Lothian. On the day of the visit, the bed capacity had been increased to 17 beds, with the use of a contingency bed located in a room previously used as the dedicated activity room. There were 18 individuals on the ward on the day of the visit, one individual was boarding in another ward overnight and returning to Craiglockhart Ward during the day. We also heard that there were six individuals boarding in Craiglockhart Ward from other wards across the hospital site.

We last visited this service in March 2022 and made recommendations regarding care plan outcomes and goals, participation of the individual in their care planning, rights-based care and returning the dedicated activity space for the purpose of activities.

On the day of this visit we wanted to follow up on the previous recommendations, in particular to find out if there had been progress made towards the involvement of the individuals in their care planning and the promotion of their rights. We also wanted to meet with individuals, carers/relatives and staff to hear their views and experiences on how care and treatment was 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 did not meet with any relatives/carers on the day of the visit however, provided the Commission's contact details for relatives/carers in the event they wanted to make contact.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), nursing staff, the recreational nurse and art therapist.

In addition, we made contact with the Edinburgh Volunteer HUB and met with senior social work managers following the visit.

Commission visitors

Kathleen Liddell, social work officer

Lesley Paterson, senior manager (practitioners)

Dr Juliet Brock, medical officer

What people told us and what we found

Comments from individuals

The individuals we met on the day of the visit were mainly positive about their care and treatment in Craiglockhart Ward. We heard that staff were dedicated to providing high quality care and that there was a consistent staff group. The feedback we heard included comments such as “staff are attentive and supportive”, “staff help me when I feel distressed”. Individuals spoke positively about one-to-one support from staff and the benefit they experienced from this interaction. We heard and saw that the ward had a whiteboard that recorded information on which staff were on shift throughout the day. Individuals fed back that this information was beneficial in knowing who they would be receiving their care from.

All individuals spoken with reported that they had regular contact with their consultant psychiatrist and generally found this positive. We heard that not all individuals were invited to attend their multidisciplinary team (MDT) meeting. This led to feelings of a lack of participation and involvement in their care and treatment. We heard from other individuals who did attend these meetings that they found this to be a positive experience.

We heard from one individual that they felt the care and treatment offered to them was mainly from a ‘medical model’ of care. The individual said they would have benefitted from a more holistic approach to their care and treatment, and that there was a gap in psychology support.

Most of the individuals we met with were not aware of their care plan, adding that they had not been involved in the compilation of it. One individual raised concerns over a lack of discharge planning, leading to anxieties that they would not have any support on discharge. The individual was supported by advocacy services to raise these concerns with the consultant psychiatrist and develop a more robust discharge care plan detailing support.

We heard from all individuals that we spoke with that the ward environment could be “loud and stressful” at times. Some individuals told us that they tended to spend time in their bedroom to avoid the communal area which they could find “intimidating”. We heard that there was a lack of quiet space in the ward for individuals to use out with their bedroom. Many individuals commented that the ward would benefit from having the dedicated activity room back in use, as this space was a therapeutic space to engage in meaningful activity.

Care, treatment, support and participation

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 being made.

We reviewed the care plans which were stored electronically on TRAK care. We found the care plans in Craiglockhart Ward to be of mixed quality. We had previously made a recommendation in our visit in 2022 that care plans should evidence each individual’s care goals and outcomes. We were disappointed to see that there has been limited progress in the quality of care plans. The care plans we reviewed lacked person-centred detail, were mainly didactic and did not evidence a strengths-based, goal or outcomes focussed interventions.

We found in some cases there was no care plan linked to an individual's presenting issue. For example, one individual did not have a specific care plan to support their mental health diagnosis and instead the care plan included generic information, which was not personalised and did not identify the presenting needs, care goals and/or outcomes.

We made a recommendation in the previous report in relation to increased participation of the individual in their care planning. We were disappointed to see and hear that there had been limited progress in promoting participation. The majority of the individuals that we spoke with were unaware they had a care plan.

We heard from some individuals that they did not attend MDT meetings, therefore were not involved in any discussions regarding their care and treatment. Individuals told us that they would like to be more involved in decisions regarding their care; the lack of progress in these individuals' participation concerned us. The current practice in Craiglockhart Ward does not align with the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) principle of participation which encourages and allows individuals to be involved in decisions about their care.

We found mixed quality discharge planning information available. Most of the individuals spoken to were unaware of discharge planning. We were pleased to see that for one individual, the discharge plan evidenced good MDT discussion and decision making, detailing robust and comprehensive discharge information and planning. For another individual, we heard and saw that there was insufficient discharge planning, leading to the individual feeling unsafe transitioning back into the community. The individual had shared their concerns with their consultant psychiatrist. This concerned us as we would have expected discharge planning to be robust, individualised and include the involvement of the community team to have an opportunity to discuss safety planning and to promote successful discharge and recovery. We found inconsistencies in the approach to discharge planning and what seemed like a disconnect between the inpatient and community model, which was not supportive of a seamless transition to support individualised recovery and positive discharge.

When we reviewed the care plans, we were unable to locate robust reviews which targeted nursing intervention and individuals' progress. We discussed this with the SCN and CNM on the day of the visit who acknowledged that improvements to care planning and reviews was required. We were encouraged to hear that a project was underway to develop a new care plan that will be specific to individuals admitted to a mental health ward. We were told that the new care plan was expected to be available on the electronic record system, TrakCare in summer 2024.

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 found regular review of the risk assessments and evidence of changes made to the risk assessment following review depending on each individual's progress or new/increased risk.

We saw that physical health care needs were being addressed and followed up appropriately by junior doctors. The medical reviews completed by the junior doctors were of a high standard and included comprehensive information that was personalised and detailed

forward planning for care and treatment. We also saw involvement from the advance nurse practitioner (ANP) where appropriate, to review physical health needs.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out and any changes required to meet care goals.

Care records

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

We highlighted in the previous report that care records lacked detail and were mainly repetitive. We were pleased to see significant improvement in the quality of the care records. The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Craiglockhart Ward. The majority of the information recorded was detailed and personalised and recorded comprehensive information on the nursing intervention individuals required throughout the day. Some of the information recorded in care records was strengths based and recorded discussions with individuals which explored their feelings and views. We were however disappointed that in some care records, language such as 'evident on the ward' and 'low profile' continued to be used, making it difficult to discern current issues or interventions. We would prefer to have seen care records that were person centred, containing detailed personalised information.

We saw frequent one-to-one interactions between individuals and staff. The recording of these interactions was comprehensive and person-centred. We heard from individuals that they found one-to-one interventions with staff positive and beneficial to their recovery.

We were pleased to see comprehensive care recording from most members of the MDT. The care records from the art therapist, speech and language therapy (SALT) and dietician were personalised, outcome and goal focussed and included forward planning. We noted a lack of occupational therapy (OT) recording in care records. We were encouraged to see regular and comprehensive review of individuals by their consultant psychiatrists.

On review of the care records, we did not find any recording of activities. Instead, we found recording of the activities in the care plan. The activity care plans we reviewed evidenced good quality recording which was person-centred, strengths-based and provided detail on each individual's experience when engaging in the activity. However, we would prefer to have seen information on activities recorded in care records so that it was easily located and recorded alongside the rest of the MDT's information. We discussed this with the SCN on the day of the visit, who agreed.

We were pleased to find that the care records included regular communication with families and relevant professionals. We were particularly pleased to see that for some individuals who were approaching discharge, contact was made with their GP to provide information on their admission and the plan for community support.

It was evident from reviewing the care records that there were high levels of clinical acuity in Craiglockhart Ward. The individuals in the ward experienced high levels of stress and distress leading to increased clinic risk due to high levels of verbal and physical aggression. We were pleased to note that the MDT were actively involved in providing the support, care and treatment to individuals at these times.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to medical and nursing staff, the MDT was made up of a recreational nurse, physician associate pharmacist and art therapist. We were pleased to see regular input, discussion and liaison from an advanced nurse practitioner, to support assessment and review of physical health care needs, SALT and dietician service in the care records we reviewed.

We highlighted in the previous report that Craiglockhart Ward had increased access to psychology input which had been beneficial to individuals and staff. We were told on the day of the visit that the psychologist had left post and there was currently no psychologist based on the ward. Although it was a concern that there was a gap in the provision of psychology to individuals in Craiglockhart Ward, we were pleased to hear that a new full-time psychologist had been recruited and would in post by April 2024. We were told that in the meantime, there was limited psychology cover however, a referral could be made to the service if required.

We also highlighted in the previous report that OTs were not based on the ward and that this arrangement was being reviewed with the view to them being more ward-based. We were disappointed to find that no progress had been made in this area. We heard that for individuals who required OT assessments/input, a referral was made to the OT service. We heard that for some individuals, admissions could be short, therefore it would be more beneficial if the OT was fully integrated into the MDT and involved in discussions and decisions regarding all aspects of risk assessment and care planning. Having a ward-based OT would promote individualised and person-centred assessments that supported a holistic approach to each individual's care and treatment in the ward.

Recommendation 2:
Managers should consider developing the multi-professional team to include regular access to occupational therapy.

We met with the art therapist on the day of the visit. We heard that art therapy was offered two days a week on the ward on a group and individual basis. The group supported individuals to work creatively to develop alternatives ways of expressing emotions, relating to others, communicating and problem solving. In addition to group work, art therapy was available on a one-to-one basis for individuals where it had been assessed by the MDT that they would benefit from this therapeutic intervention.

When reviewing the individuals care records, we saw that some individuals who were subject to Mental Health Act legislation had an allocated mental health officer (MHO) however, we also found that some of these individuals had not. One individual told us that they had not been allocated an MHO throughout the duration of their detention period. The individual told us that they felt the allocation of an MHO would have been supportive in relation to discussing their rights. The individual also held the view that the presence of an MHO during the review of their detention would have offered additional safeguards in relation to a more holistic and rights-based care approach to their care and treatment.

We have raised concerns with City of Edinburgh senior social work managers with regards to the current MHO allocation system. We were told that the allocation of MHOs to detained individuals was being reviewed, with a view to allocating MHOs immediately following the granting of a detention. We will continue to monitor the situation.

Each consultant psychiatrist dedicated to the ward held weekly MDT meetings. In attendance at the meeting were medical staff, nursing staff, pharmacy and at times, art therapy. In addition to these meetings, we heard that there were various other MDT meetings taking place due to the ward having individuals boarding from other wards. On review of the MDT meeting paperwork, we found that there was an inconsistency in relation to attendance and involvement of the individual. For some individuals, they were invited to attend their MDT meeting round however, for others they were not invited to attend. We did not see consistent evidence of relatives/carers attending these meetings, however we did see communication with relatives/carers and their views were discussed as part of the meeting.

We discussed the importance of promoting the principle of participation and supporting all individuals in Craiglockhart Ward to participate as fully as possible in any decisions made with the SCN and CNM. They agreed that given the feedback from the individuals during the visit, a review of the current MDT meeting arrangements would be undertaken to consider how the participation of all individuals could be increased.

The MDT meetings were recorded on a mental health structured ward round template and held on TrakCare. The template had headings relevant to the care and treatment of the individuals in Craiglockhart Ward. We found that the majority of these records were comprehensive and contained detailed recording of the MDT discussion and decisions which promoted a holistic approach to each individual's care. We noted that for individuals who were boarding in Craiglockhart Ward, the record of the MDT meeting was not as comprehensive and did not have full MDT attendance, nor evidence participation. We raised this with the CNM and SCN on the day of the visit. The CNM agreed to raise these issues with the consultant psychiatrists who were responsible for individuals' boarding in Craiglockhart Ward to ensure parity of care and treatment.

Recommendation 3:
Managers should ensure individuals are supported to have meaningful participation in care planning and decisions about their care and treatment and this participation is recorded within their clinical record.

Use of mental health and incapacity legislation

On the day of our visit, 12 individuals in the ward were detained under the Mental Health Act. We found the forms relating to each individual's detention stored electronically on TRAK.

The individuals we met with during our visit had a mixed understanding of their detained status under the Mental Health Act and of their rights regarding this. However, we were pleased to note from the files we reviewed that there was evidence of legal representation and advocacy involvement to support individuals understand their legal status and exercise their rights.

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 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 if the individual is consenting.

We reviewed the prescribing for all individuals, as well as the authorisation of treatment for those subject to the Mental Health Act. We found two individuals who had T2 certificates that the medication recorded on the T2 did not correspond with the prescribed treatment. We highlighted this issue on the day of the visit and were assured by the CNM and SCN that an urgent review of the T2 certificates would be undertaken.

Medication was recorded on the electronic prescribing system '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 ease of checking the correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason, we suggested during the visit 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.

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. From the files we reviewed, we found that a section 47 certificate that had been completed, did not have an accompanying treatment plan. We raised this with the CNM and SCN on the day of the visit.

Rights and restrictions

Craiglockhart Ward continued to operate a locked door, commensurate with the level of risk identified with the individual group. The ward had a locked door policy that was displayed at the entrance door.

We made a recommendation after the previous visit in relation to improving the delivery and provision of information of rights-based care and recording this in each individual's care plans.

We were disappointed to see that there had been limited progress on this recommendation. The individuals we met with had mixed knowledge of their rights. Some individuals did not know they were detained and had no awareness of their rights in relation to the detention. We saw that each detained individual received a letter from medical records following detention under the Mental Health Act that included information on their detained status and their rights in relation to this. However, for some individuals, this was insufficient in supporting their understanding and knowledge of rights and more proactive work was required. We discussed this on the day of the visit with CNM and SCN and highlighted that in other areas of NHS Lothian there was a care record titled 'rights read' which promoted discussion regarding rights. We also discussed consideration for options to make rights information more widely, for example the use of QR codes and/or information on rights being visible in the ward to promote right based care being delivered to individuals. The CNM and SCN agreed this promotion of right based care was priority and would liaise with quality improvement services to ensure this was delivered to all individuals.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. Two individuals were specified on the day of the visit. Where specified person restrictions were in place under the Mental Health Act, we found one comprehensive reasoned opinion and regular review of the restrictions in place. For the other individual, we were unable to find a reasoned opinion. There also appeared to be some confusion in ward staff about what restrictions were in place and for whom. We raised with the CNM and SCN on the day of the visit that the RMO must complete a reasoned opinion recording why restrictions are required. It is also important that staff are aware of the specified person status for each individual subject to these restrictions.

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

We asked individuals how they communicated feedback regarding the ward environment and their care to the staff team. We were told by the individuals we met with that there was no forum in the ward to provide feedback and views. We heard there used to be community meetings held in the ward however these stopped during the Covid-19 pandemic and did not restart. We discussed with the SCN concerns that there was no system in place for individuals to provide feedback and views to staff. The SCN agreed to restart community meetings as a matter of priority.

When we are reviewing each individual's files, we looked for copies of advance 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. Health boards have a responsibility for promoting advance statements. One individual told us that they were in the process of making an advance statement. Some of the individuals we spoke to were aware of advance statements however had chosen not to complete one. Others were unaware of advance statements. It was evident from review of the individual files and during discussion with some of the individuals that they were not at a point in their recovery to be able to make decisions

regarding their care and treatment. We discussed with the CNM and the SCN the responsibility of the health board in promoting advance statements and made suggestions such as including advance statement discussion into the ward round meeting as well as discharge planning discussions.

We were told that advocacy is provided regularly in the ward by advocacy service, Advocard. We were told that advocacy attended the ward on request and provide a good service to individuals who wished to engage with them. We were pleased that all of the individuals 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 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

Recommendation 4:
Mangers should ensure that rights-based care is delivered to individuals and recorded in their care plans. Managers should ensure that information on rights is easily available and visible throughout the ward.

Recommendation 5:
Managers and the responsible medical officer (RMO) should ensure that when individuals are subject to specified persons procedures, the appropriate paperwork, including a reasoned opinion should be completed to authorise the restrictions.

Activity and occupation

We heard and found evidence of a range of activities that were available to individuals in Craiglockhart Ward. The activity and occupation in the ward was mainly provided by the recreational nurse however, the art therapist and volunteers also supported activity on the ward. The individuals we met with spoke positively and were complimentary about the recreational nurse and the activities and occupation offered in the ward. However, all individuals we met with told us that they would prefer the activities to take place in a dedicated activity space. We heard from some individuals that they did not always attend activities as they found it too difficult to attend the communal ward space as it could feel "intimidating and loud". We heard that this space did not provide a therapeutic environment and there was often the competing demands of other individuals who were not engaging in the activity making tea, watching TV or meeting family in the same space.

We met with the recreational nurse who raised concerns in relation to environment and the negative impact on each individual's experience of engaging in therapeutic activity. We heard that due to the lack of appropriate space, there were limits to the therapeutic activities that could be offered. We were told that there was a regular activity programme of arts and crafts, pampering, coffee mornings, visits to the local shops and quizzes. We heard that staff and individuals had requested to use the OT kitchen however were advised that this was not possible. We heard that some individuals attended the HIVE day service, which was an activity centre situated in the grounds of the hospital. We saw activities and art therapy taking place

in the communal area on the day of the visit and noted that the environment was not appropriate due to the level of noise and the amount of people congregating in the area.

We made a recommendation following the previous visit that there should be a dedicated activity space in the ward. The response from NHS Lothian senior managers in relation to this recommendation stated "where admission demand allows, the dedicated activity room will be reinstated for use as intended" and "communal ward space will be made more conducive for activities to take place in this space on occasions that the dedicated activity room cannot be utilised due to demand on bed capacity". We were disappointed that the response from senior managers had not been progressed and the situation remained that there was limited and inappropriate space for individuals to engage in activity. Individuals were clear in their view that the lack of opportunity to engage in regular activity negatively impacted on their admission experience to Craiglockhart Ward and they often found themselves feeling bored and isolated. Other staff also reported that the lack of therapeutic space negatively impacted on the quality and type of activities that could be offered and each individual's experience of participating in activity in Craiglockhart Ward.

We heard and saw volunteer involvement in the ward. On the day of the visit, two volunteers attended the ward, one to offer nail painting and the other to offer a therapet session. Both sessions were well attended by the individuals in the ward who provided positive feedback. We made contact with the volunteer HUB following to the visit and were told that the positive support of the recreational nurse in Craiglockhart Ward made it possible for a range of volunteers to attend an acute ward setting and feel confident to work with individuals who can experience acute mental health issues.

We were pleased to hear from the recreational nurse that a garden project was being considered with a view to refurbishing the garden area and developing a more therapeutic outdoor space for individuals to use and for activities to take place in the summer months.

Recommendation 6:
Managers must consider providing a dedicated space in the ward for the purpose of activities.

The physical environment

Craiglockhart Ward had recently been painted which promoted a bright and clean environment. However, the ward did appear clinical as the art work and paintings had not been placed back on the walls. We were told that art would be placed back on the walls as soon as the decoration of the ward was finished in order to create a more welcoming, homely and therapeutic environment.

The lounge and dining area were situated at the entrance of the ward. Individuals tended to spend a lot of time in these communal areas and we observed it was busy on the day of the visit with individuals using the areas to watch TV, have a hot drink and use the space to meet with family. The individuals were able to use the kitchen facilities which were attached to the communal area to make a hot drink and snack and had access to the outside courtyard until midnight. On occasion during the visit, there was a high volume of noise in these areas and it was easy to understand why some individuals found the communal area intimidating.

We were able to see some of the individuals' bedrooms. The bedrooms viewed had ensuite facilities and were personalised.

We raised in the previous report that we had concerns over the use of the dedicated activity room in the ward. We again found that on the day of the visit, the activity room had a surplus bed in it. This room did not have washing or toilet facilities, compromising the individual's right to privacy and dignity. Although we recognise the national shortage of beds, we do not consider using the activity room to be appropriate or safe as an individual's bedroom.

We heard and saw that some individuals admitted to Craiglockhart Ward were boarding from other wards. We heard for one individual they were boarding in another ward at night across the hospital site and returned to Craiglockhart Ward during the day. The individual did not have a dedicated bedroom. We were concerned that the regular change in care arrangements and environment could be unsettling and negatively impact on each individual's consistency of care, treatment and recovery. 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, individuals were asked to board in other wards overnight. We were told that senior managers were aware of the negative impact boarding had on individuals and all efforts were made to adhere to NHS Lothian Bed Management Policy.

We raised in the previous report that individuals continued to smoke in the courtyard and found this still to be the case. We were told that NHS Lothian were reviewing all smoking policies in order to support the implementation of the Scottish Government law passed in September 2022 which prohibited smoking in hospital building and grounds. On the day of the visit, we saw individuals smoking in the courtyard and saw signage requesting that they discard their cigarette butts in the bin. Individuals and staff spoken to reported that it had been difficult to support the implementation of the current legislation. We are aware of the challenges for individuals not being able to smoke, which for many was against their views and wishes. We also heard from individuals who did not smoke and the negative impact smoking in the courtyard had on them. We discussed with the CNM and SCN and advised that more proactive approaches to support the implementation of the non-smoking law such as non-smoking signage in the ward, nicotine replacement and smoking cessation support should be available. Individuals and staff require clear guidance and support from senior NHS Lothian managers to support implementation of the current legislation.

Recommendation 7:
Managers should consider and review current bed management and boarding arrangements to ensure each individual's safety, welfare and well-being are prioritised.

Any other comments

We heard that there were staff shortages in the ward, mainly band 5 staff nurses and band 3 healthcare support workers vacancies and there was some use of bank staff. We were pleased to hear that bank staff were not used regularly, which promoted consistency of care.

We heard that there were regular training opportunities for staff and that staff had access to a wellbeing facilitator to promote their wellness at work. All the staff we spoke to told us that they were happy working in the ward and that staff morale had increased in recent months.

We heard that there had been three SCNs in Craiglockhart Ward since the previous visit and the changes had been difficult for the staff team to navigate. We were pleased to hear from all staff spoken to, that they felt supported by the current SCN, who is relatively new into post, and that the appointment had been very positive for the ward and has supported staff's skill development and confidence in undertaking their role. We were pleased to observe the positive working culture the SCN had promoted in the ward setting and it was evident that the ethos of the ward was a commitment to ensure and support staff to provide high standards of care.

Summary of recommendations

Recommendation 1:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out and any changes required to meet care goals.

Recommendation 2:
Managers should consider developing the multi-professional team to include regular access to occupational therapy.

Recommendation 3:
Managers should ensure individuals are supported to have meaningful participation in care planning and decisions about their care and treatment and this participation is recorded within their clinical record.

Recommendation 4:
Mangers should ensure that rights-based care is delivered to individuals and recorded in their care plans. Managers should ensure that information on rights is easily available and visible throughout the ward.

Recommendation 5:
Managers and the responsible medical officer (RMO) should ensure that when individuals are subject to specified persons procedures, the appropriate paperwork, including a reasoned opinion should be completed to authorise the restrictions.

Recommendation 6:
Managers must consider providing a dedicated space in the ward for the purpose of activities.

Recommendation 7:
Managers should consider and review current bed management and boarding arrangements to ensure each individual's safety, welfare and well-being are prioritised.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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