Mental Welfare Commission for Scotland

Report on announced visit to:

The William Fraser Centre, The Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 11 March 2024

Where we visited

The William Fraser Centre is part of NHS Lothian's learning disability service, located in the grounds of the Royal Edinburgh Hospital. The William Fraser Centre has a total of 12 beds and is divided into three areas, Strathaird, Culzean and Rannochmor. The centre is the main admission service for people with learning disabilities across NHS Lothian. It admits individuals with a mild to moderate learning disability, who may have additional difficulties, such as mental ill health, forensic needs, autism, and/or challenging behaviour.

On the day of our visit, there were 11 individuals in the William Fraser Centre. We heard that during the Covid-19 pandemic, the bed capacity was reduced to ten however, there remained capacity for 12 individuals. There were seven delayed discharges on the day of the visit. A delayed discharge occurs when an individual who is clinically ready for discharge continues to occupy a bed, usually because of delays in securing a placement in a more appropriate setting. We heard that some individuals were actively involved in discharge planning.

We last visited this service in June 2022 on an announced visit and made recommendations around care planning, authority to treat certificates, advance statements, section 47 certificates and specified persons procedures. The response we received from the service included actions that a review of the treatment plans would be undertaken, and regular audits implemented. The service also reported that a central folder would be created to store all authority to treat, specified persons and section 47 documentation, to support staff awareness of the legal frameworks which authorise treatment and any restrictions in place.

On the day of this visit, we wanted to follow up on the previous recommendations, meet individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on the ward.

We heard that a new project to develop a person-centred care plan was underway across the Royal Edinburgh Hospital site. We were told that William Fraser Centre staff were involved in the project. On the day of the visit, we heard that the service was trialling the new care plan on one of the individuals in the centre and would feedback views on the new care plan template to the project team before it was implemented for all individuals.

Who we met with

We met with, and reviewed the care of six people, six who we met with in person and five who we reviewed the care notes of. No relatives/carers requested to meet with us.

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

Following the visit we made contact with advocacy services.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

The individuals we met with reported positive feedback regarding their care and treatment in the William Fraser Centre. All individuals reported that they felt supported by staff, that staff knew them well and that they had regular one-to-one contact with their key nurse and consultant psychiatrist, which they found positive. We were told by individuals that the support in relation to physical health care was "excellent" and for one individual we heard that they were "the healthiest and fittest I have ever been". We heard that individuals benefitted from a multidisciplinary team approach (MDT) and found the input from all disciplines, such as psychology, occupational therapy (OT), art and music therapy and third sector agencies supported a holistic approach to each individual's care and treatment.

All individuals stated that they were happy with their weekly activity timetable and that they participated in activities they enjoyed and which supported their discharge plan. All individuals told us that they were aware of discharge planning and that the introduction of the discharge co-ordinator had improved participation in these plans. Some individuals were frustrated at the length of time they had been in the ward and the lack of housing and supports available in the community to facilitate their discharge. We were pleased to see that for these individuals, they had regular support from advocacy and legal representation.

Some individuals told us that they found it difficult sharing communal spaces with other individuals who had more complex needs. This caused some individuals to feel frustrated and "annoyed", leading to them spending increased periods in their bedrooms. We were pleased to hear that these individuals were offered support from staff when they experienced these challenges.

We heard from most individuals that they felt the building needed renovation and repair, with one individual saying the building "was not fit for purpose" and "we need a new building". One individual reported that they had damp patches on their bedroom ceiling which caused them to worry about their safety. We also heard that individuals did not like sharing bathrooms, as they felt it compromised their privacy and dignity.

Some of the individuals we met with raised that they would like increased contact with their mental health officer (MHO). We heard that MHO contact tended to be before a mental health tribunal. Given that some individuals we met with were subject to more than one legal framework, they felt that they would benefit from more frequent MHO input and support to discuss their legal status, rights, restrictions and any powers granted by the court. The Commission have regular contact with senior social work managers across Lothian and will communicate this information.

Care, treatment, support and participation

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care and intervention; 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 saw that individuals in the William Fraser Centre had care and treatment plans to support admission goals, outcomes and identified plans of nursing care. These were stored in paper

files. We had raised a concern during the previous visit that the care and treatment plans tended to be risk-focused to the detriment of a strengths-based approach. We were pleased to find a significant improvement in the quality and range of information recorded in the care and treatment plans.

From reviewing these plans, we saw that the individuals in the William Fraser Centre had a wide range of complex mental and physical health needs. We saw that for the majority of individuals, they had multiple plans to support all aspects of their care and treatment in the hospital and in the community. The information in these plans comprehensively detailed the care, treatment and support the individual required, providing a clear understanding to staff as to what nursing intervention was necessary to provide the support. We heard and saw that this level of detail was fundamental in providing consistency and continuity of care for the individuals in the William Fraser Centre.

The information in these plans was person-centred, evidenced a strengths-based approach and a focus on recovery to support discharge. We found that the MDT were fully involved in the care and treatment plans, which supported a holistic approach to care. All of the individuals had been supported to complete a health passport and an 'All About Me' template that provided personalised information and views on what was important to individuals in relation to their care and treatment. This information was reflected in plans and promoted the individual's participation. We saw that where appropriate, relatives/carers had input into care and treatment plans, providing information and their views.

We saw regular reviews of the care and treatment plans, with the majority of the reviews being comprehensive, and providing a summative evaluation of the individual's progress. Many of the reviews included input from all members of the MDT. We saw care and treatment plans being adjusted following reviews, to support any areas of progress or elements of increased support needed. We found that on a limited number of occasions that some treatments recorded 'no change' following review. While we understand that the lack of change was due to restrictions imposed by the legal order granted (compulsion order with a restriction order), we discussed with the SCN that review of the intervention was required to regularly assess if the targeted nursing intervention remained relevant. The SCN agreed to discuss this with the team.

The risk assessments we reviewed were of a very high standard. Some individuals had various risks assessments that supported them in the ward and in the community. The level of detail in the risk assessments was robust and included identified risks, a detailed risk management plan and a safety plan. This level of detail supported all staff working with the individual to have a good awareness of the support they needed to provide to ensure the individuals and others safety.

Physical health care in the William Fraser Centre was provided by the junior doctors and the nursing team. We heard that many of the nursing staff were trained in various physical health care treatments including taking bloods and providing stoma care. This supported consistency of care for the individuals in the William Fraser Centre who could find it difficult to engage with unfamiliar medical staff. We were pleased to see that individuals were involved in national annual health screening programmes. When reviewing physical health treatment

plans, we were pleased to find a focus on physical well-being support and promotion of healthy nutrition and physical activity. We saw that some individuals had easy read and pictorial information booklets to support their understanding of the physical health diagnosis. We were pleased to see that for one individual, this information had supported their engagement in the treatment of the diabetes, resulting in improved physical health.

All individuals were subject to the care planning approach (CPA). CPA is a framework used to plan and co-ordinate mental health and / or learning disability care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. We found this paperwork to be of a high standard and regularly reviewed.

Care records

Information on individuals care and treatment was held electronically on TRAKCare. We found this easy to navigate. The care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in the William Fraser Centre.

The care notes we reviewed were of good quality and evidenced person-centred, individualised information, detailing what activities the individual had engaged in that day and what had been positive or challenging for them. The information in the care records focused on the strengths of the individuals, encouraged skill development and independence. We saw that information recorded in the care records aligned with the treatment plans. We were pleased to see comprehensive recording from all members of the MDT. The care records from OT, psychologist, discharge co-ordinator, art psychotherapist and music therapist were personalised, outcome and goal-focused, and included forward planning. We were pleased with the improved quality of the of the care records and the holistic and recovery-based approach offered to the care of individuals in the ward.

There was evidence of frequent one-to-one interactions between individuals, nursing staff and their consultant psychiatrists. The individuals we met with told us that they met with their key nurse and other members of the MDT regularly. The one-to-one interactions reviewed were comprehensive, personalised and person-centred. There were examples of nursing staff and the consultant psychiatrists asking individuals their views on the treatment plan, discharge planning and discussions on care and treatment issues. We saw that in some cases, where individuals were unhappy with elements of their treatment plan, staff explained the rationale for the support as well as providing information on the individual's rights and how these could be exercised.

We were pleased to find that the care notes included regular communication with families and relevant professionals. Many of the individuals in the William Fraser Centre had involvement with third sector providers. The communication with the providers was clearly recorded in care records.

Multidisciplinary team (MDT)

The MDT consisted of two consultant psychiatrists, a junior doctor, nursing staff, speech and language therapy (SALT), OT, art psychotherapist, music therapist and a discharge co-ordinator. All of the individuals had allocated MHO's. Some of the individuals had an allocated

social worker. We heard that the allocation of a social worker tended to be when discharge was imminent.

Each consultant psychiatrist held a weekly MDT meeting. Each individual met with their key nurse before the meeting and discussed any issues or questions they wanted raised in the meeting. We heard and saw that the consultant psychiatrist met with the individual following the meeting to discuss the outcome. Most individuals were happy with this arrangement and felt it supported their participation without the requirement to attend the meeting, which they could find anxiety provoking. One individual reported they would have liked the opportunity to attend the meeting as they did not find the current arrangement offered full participation in discussion and decision-making. We raised this with the CNM and SCN and they agreed to discuss this matter with the individual and the MDT.

The MDT meeting record had changed since our previous visit, and had significantly improved in the quality and detail of information recorded. The meeting was recorded on a structured MDT meeting template. We found detailed recording of the MDT discussion, decisions and personalised care planning for individuals. We were pleased to see clear links between MDT discussions and the treatment plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission. It was clear that the MDT was fully involved in the care of individuals in the William Fraser Centre and committed to adopting a holistic and strengths-based approach to the individuals care and treatment.

Use of mental health and incapacity legislation

Individuals in the William Fraser Centre were subject to a range of mental health and incapacity legislation, and in some instances, individuals were subject to both. On the day of our visit, 10 individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), and there was also use of s57 of the Criminal Procedure (Scotland) Act 1995, with a number of individuals subject to Adults with Incapacity (Scotland) Act 2000 (the AWI 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. During the last visit, we found that many individuals did not have valid T3 certificates authorising prescribed treatment and we made a recommendation in relation to this. We pleased to find that the action taken by the service in response to this recommendation had been implemented. A folder that included a paper copy of all T2 and T3 certificates had been created. The folder supported nursing and medical staff

to have easy access to, and an opportunity to review all T2 and T3 certificates and noted an improvement in valid T3 certificates.

On crosschecking each electronic record, we identified a situation where the prescribed treatment was not authorised on a T3 certificate. We provided details of the individual to the SCN and were advised that the responsible medical officer (RMO) would urgently review these T3 certificate.

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 all documentation recorded on TRAKcare.

For those people that were under the AWI Act, we found all documentation including powers granted and details of proxy decision makers. The individuals we met with who were subject to guardianship under the AWI Act had a good understanding of what this meant for them.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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. We found all individuals had a section 47 certificate in place, accompanied by a comprehensive care plan.

Rights and restrictions

The William Fraser Centre continues to operate a locked door, commensurate with the level of risk identified with the individual group. Information on the locked door policy was available at the main entrance to the centre.

The individuals we met with during our visit mainly had a good understanding of their rights. Most 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 throughout the William Fraser Centre, including easy read information on rights and a letter that 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.

The William Fraser Centre had a seclusion room and seclusion procedures. In discussion with the SCN, we were made aware that the use of seclusion had significantly reduced, with the use of more therapeutic interventions being used to manage periods of stress and distress. We had raised our concerns over the use of bedroom seclusion in previous reports. From reviewing the care records, and during discussion with individuals, we did not find any use of bedroom seclusion. We were pleased to be told that the use of bedroom seclusion had also significantly reduced, although this continued to be used at times. We were told that when seclusion was used, it documented clearly on HEPMA and included as part of the individual's treatment plans.

We were also pleased to hear that the level of restraint in the William Fraser Centre had reduced. The service had recently purchased a safety pod to use if restraint was required. We

heard that the safety pod promoted a more dignified, safe and compassionate approach to restraint for individuals who required it.

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 a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found all relevant documentation completed, including a comprehensive reasoned opinion and regular review of the restrictions in place.

When we are 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 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. During the previous visit, we were disappointed to find that no individuals in the William Fraser Centre had advance statements and made a recommendation in relation to improved promotion of advance statements. We were therefore pleased to find that there had been an increase in the number of individuals who had completed an advance statement.

We heard from individuals that we met with and staff in the unit that advocacy support was easily available on the ward. Following the visit, the Commission contacted the advocacy services who attended the William Fraser Centre; we were told that individuals engaged well in advocacy support and that staff supported this involvement. We heard that on limited occasions, communication had been problematic and that arranged visits to individuals did not go ahead due to the appointment not being recorded in the ward diary. Nevertheless, we saw from a review of the care records that advocacy attended the ward regularly and supported individuals who were involved in discharge planning and CPA meetings.

We were pleased to note that many of the files we reviewed recorded that the individuals had legal representation. For those individuals unable to organise legal representation, a curator ad litem had been requested to safeguard the interests of the individual in proceedings before the Mental Health Tribunal for Scotland.

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.

Activity and occupation

We heard, and found evidence of, a broad range of activities that were available for individuals in and out with the ward. The activities in the William Fraser Centre were mainly provided by Band 3 nursing staff and OT assistants.

We were pleased to find each individual had an activity treatment plan and timetable that recorded a programme of activities related to the individual's interests, assessed needs, goals and outcomes. The activity treatment plans were person-centred and focused on what activities supported the admission outcomes and discharge planning. We were pleased to find many activity timetables included vocational and educational activity and occupation.

We met with individuals who told us they spent a lot of time engaging in community activities and were supported by third sector agencies. This additional support had been commissioned by social work to facilitate discharge planning. Individuals that we spoke with were positive about this support.

There were activity boards with details of various activities available in the three units. Activities include art psychotherapy, music therapy, outings to the local community parks and cafes, visits to the HIVE day service, board games, darts and shopping trips. We heard, and saw that the William Fraser Centre previously had therapy ponies in the unit that individuals found enjoyable, and which had been a positive experience. Individuals have requested a further visit from the therapy ponies and have agreed to take part in fund raising activities to provide this activity. We saw that some individuals and staff had participated in a sponsored 5km walk which raised money for a further therapy pony visit.

Some individuals raised they would like the opportunity to have greater access to activities that promoted skill development and independent living skills. For example, we heard that there was no working kitchen in the William Fraser Centre. We heard that cooking groups were arranged on occasion however, individuals reported they would like the opportunity to prepare and cook some of their own meals in the ward.

The William Fraser Centre had support from the Cyrennian's volunteer group to help develop their garden. The Cyrennians attended the unit regularly and offered group and individual gardening sessions.

The physical environment

William Fraser Centre is divided into three areas, Starthaird, Culzean and Rannochmor. On the day of the visit, Strathaird had three females and one male (who had his own private area) Culzean had four males and Rannochmor three females. All individuals had their own bedroom which was personalised. Most individuals used shared bathroom facilities. Feedback from individuals was that they would prefer en-suite bathroom facilities to promote their privacy and dignity.

Strathaird and Rannochmor had developed a 'pod' in each unit. The pod included a living space, bedroom and ensuite bathroom. We heard from some individuals that they would prefer and benefit from being in a pod, as it would promote their independent living skills and support discharge planning into a community setting.

Each unit had a communal area which had a TV, books, board games, soft furnishings and decoration, such as wall art to make it more homely.

When undertaking an environmental review of the units, we saw that improvements to the environment were required. While we saw high standard of cleanliness, we were concerned to see parts of the building that required the décor being refreshed and repairs completed. In particular, we saw many patches of damp on the ceiling and carpets that needed replaced. We were told that inspection of the roof had been undertaken and some repairs were required. We were pleased to hear that there were plans to complete the roof repairs. We also heard that the ward management team had met with estates and made suggested changes to improve the ward environment. These changes included ensuite facilities for all individuals,

renovation of the kitchen to allow individuals and groups to use it, and increased storage. We heard that these improvements were costly and would not be considered until the repairs to the roof were completed. While we were encouraged to hear about potential environmental improvements in the units, this should not prevent essential repair and decoration work being completed.

Recommendation 1:
Managers must prioritise addressing the outstanding environmental issues in relation to repairs, updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Any other comments

The staff team had a mixed experience and skill, which complemented the care and support being offered to individuals in the William Fraser Centre. We met with some staff who had worked in the unit for many years, as well as newer qualified staff. We saw and heard that the team supported each other and had created a positive working environment.

We heard that staffing levels had improved since the previous visit. The service had undertaken work to retain staff as well as recruit new staff which had been successful. There remain vacancies, however, we heard that the team, alongside regular bank staff, covered shifts, which promoted consistency of care for the individuals in the William Fraser Centre.

Following on from an iMatter survey (designed to help individual staff and teams understand and improve staff experience), staff fed back that they would benefit from increased one-to-one supervision. We heard that this had been implemented alongside staff completing quarterly professional development planning (PDP), which supported staff to reflect on their own learning, performance and career development. We heard that staff were offered reflective practice support from psychology and counselling was also available to staff.

We saw and heard evidence of good leadership in the William Fraser Centre. The SCN was new in post when the Commission last visited. We were pleased to see the changes which had been implemented and progress made since the visit in June 2022. It was positive to hear from all staff spoken to, that they felt supported by the current SCN, and that the appointment had been very positive for the ward, as well as supporting 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. It was evident that the ethos of the ward was a commitment to ensure and support staff to provide high standards of care and strive to provide holistic, strengths-based, and recovery-focused care.

Summary of recommendations

Recommendation 1:
Managers must prioritise addressing the outstanding environmental issues in relation to repairs, updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Service response to recommendations

The Commission requires a response to this recommendation 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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