

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Robert Fergusson Unit, Royal Edinburgh Hospital, Morningside
Place, Edinburgh, EH10 5HF

Date of visit: 3 October 2023

Where we visited

The Robert Fergusson Unit is a national NHS neurorehabilitation service for patients with acquired brain injury and associated behavioural disturbance. The unit is staffed by a multidisciplinary team with specialist skills neuro-behavioural rehabilitation.

The unit was initially designed with capacity for 20 inpatients, but beds continue to be capped at 18 for reasons of safety and to ensure adequate provision of staffing to meet the needs of individuals. On the day of our visit, there were 16 individuals on the ward.

We last visited the service in March 2022 on an announced visit and made one recommendation for managers to consider how clinical records held on paper files could be incorporated into the electronic individual management system. We commended the service on significant improvements made over recent years and on the commitment of the team to an ongoing programme of quality improvement work. There was a three-year strategy in place, including goals to improve training, audit and research.

This visit was carried out unannounced, not due to any new concerns about the service, but as part of the Commission's regular programme of both announced and unannounced visits.

On the day of this visit, we wanted to hear about the current experience of individuals and carers, to follow up on the previous recommendation and to seek an update on the quality improvement programme of work.

Who we met with

We met with and reviewed the care of eight people. We also met with two sets of relatives.

We spoke with a senior manager, consultant psychiatrist, occupational therapy (OT) lead and a number of nursing staff.

Commission visitors

Juliet Brock, medical officer

Tracey Ferguson, social work officer

Lesley Paterson, senior manager (practitioners)

What people told us and what we found

Care, treatment, support and participation

We observed positive interactions between staff and individuals throughout the visit and the ward felt calm and relaxed on the day. Staff we spoke with had a good knowledge of the individuals under their care.

The two carers we spoke with were positive about the staff and the care their loved ones were receiving. They also spoke of good communication from the ward team.

At the time of our visit, three individuals required continuous interventions (two due to falls risk) while another person had support needs requiring four staff for all personal care. Although alternatives to reduce the need for continuous interventions were being actively explored (such as using electronic equipment to monitor falls in those at risk), the requirements for intensive support remained high and the staff team spoke of feeling stretched. Concerns were also expressed by the staff team about their ability to provide rehabilitation support to the wider individual group in this context.

Staff from across the multidisciplinary team explained that the needs of individuals in the unit had changed over time, with a greater number of people now being admitted with complex medical co-morbidities and significant physical care needs. The rehabilitation pathways for these individuals could also be very different from those of people typically treated by the service in the past; for example, the ongoing care for some individuals now required a care home setting with full time nursing provision, rather than discharge to independent/supported accommodation in the community with a package of care.

Those with needs that are more complex also required a different approach in terms of activities. The OT told us there had been an awareness among the team of the need to offer more sensory-based activities as a means of providing communication and support, so they were liaising with colleagues across the UK to develop this aspect of practice within the service.

Multidisciplinary team (MDT)

The MDT continued to include nursing, OT, art therapy, speech and language therapy (SaLT) and a medical team comprising of two consultant neuropsychiatrists and an associate specialist. There was also social work representation at the MDT. Physiotherapy input to the service was well resourced, with daily visits.

There was no clinical psychologist in the team and no plans to introduce psychology. The two consultant neuropsychiatrists carried out assessments and formulation, undertook therapeutic work such as cognitive-behavioural therapy (CBT) with individuals, and devised behavioural management plans with the MDT.

The outreach role in the service was on hold at the time of our visit due to maternity leave.

Senior nursing staff explained that staffing had been more of a challenge for the service since the Commission's last visit. There had been difficulties with nursing recruitment at all levels and 30-40% of health care support worker posts remained vacant. Use of bank and agency

staff had been necessary to cover shifts on the ward. We were told that at times, when gaps in staffing were foreseen, bank and agency staff were block-booked to ensure continuity of care for individuals wherever possible. Managers advised that bed numbers had been further reduced to ensure safe care amidst these challenges.

Encouragingly, there had been recent recruitment of new health care support workers and staff nurses, who were soon to come into post.

Despite these challenges, the staff we met with continued to be very positive about working in the service and spoke about good leadership in the MDT, and ongoing support from managers overseeing the service. There was also a focus on striving to further improve and develop the service, with quality improvement projects continuing.

Care records

We found that the care records remained somewhat disjointed. The majority were held on TRAKcare, the electronic individual record management system used by NHS Lothian, but some were still held on a shared drive used by the service and others on paper.

The daily entries on TRAK appeared to be less detailed than we found previously (on the last visit we had commented on the excellent quality of these recordings). The use of canned text was variable and the information provided in the nursing entries we viewed appeared minimal. We recognised that this change may be in part a reflection of recent staffing changes and challenges. In contrast, recordings by other members of the MDT, including OT and SaLT, provided detailed notes of one-to-one work undertaken with individuals. We also saw evidence of medical reviews and input from art therapy and physiotherapy.

MDT meeting records were variable; it was good to see examples where individual's mental health act status was recorded, with dates of the expiry of the order being included, along with details of current T2/T3 certificates providing authority to treat, however, this was not always present. Overall, records of some MDT meetings and discussions were more comprehensive than others.

In the paper records, we found initial assessments, rehabilitation care plans, 'Getting to Know Me' information and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. We found initial assessment documents to be very detailed, along with highly personalised individual rehabilitation support plans. However, in the records we reviewed, the latter were often out-of-date and appeared not to have been reviewed for over a year.

The individual care plans held on TRAK were limited and lacked detail. On our last visit, staff explained that the care plan templates on TRAK were not designed to support mental health care planning and did not meet the needs of the service or the specific individual group. We were aware that there has been ongoing work in the health board to pilot revised versions of mental health care plans on TRAK and that training to implement this was due to be provided in the future.

It was a concern however, that among the records we viewed on this visit, we could not see evidence of stress and distress care plans on TRAK for a number of individuals for whom these would have been indicated. We were advised that the team used the RAID (Reinforce

Appropriate, Implode, Disruptive) model for managing challenging behaviour and that RAID care plans were held on the paper files for some, but not all individuals. We were told that there were plans to increase access to RAID training for staff.

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

<https://www.mwcscot.org.uk/node/1203>

Recommendation 1:

We repeat our previous recommendation that managers should consider how essential clinical information currently held on individuals' paper records could be incorporated into the electronic individual management system.

Recommendation 2:

Managers should undertake audit and improvement work around nursing care plans to ensure these reflect current care goals for the individual and are regularly reviewed and updated as appropriate.

Use of mental health and incapacity legislation

On the day of the visit, 13 of 16 people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). We found copies of Mental Health Act documentation both on the electronic record system 'SCI store' and in individual paper files.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Copies of consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were collated in one folder for ease of reference, and were in place where required.

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. We found that the section 47 certificates we reviewed were appropriately completed, authorised and up-to-date.

With regard to individuals who had a welfare proxy decision maker under the AWI Act, we found that copies of documentation were not always present in the files we viewed. For example, in one person's records, references to welfare guardianship were made throughout, but no copy of a guardianship order could be found in their hospital records (and we found no evidence of a guardianship order being in place on later checking the Mental Welfare Commission's records)¹. In another example, an individual was said to have a welfare guardian, but we could find no record of appropriate consent being sought or granted when

¹ When individual guardianship orders are granted by the courts, notification and a copy of the order are sent to the Commission.

photographs of the individual were taken in relation to specialist medical (dermatological) care while in the unit.

There was apparent confusion among staff about which individuals had a welfare attorney or welfare guardian under the AWI Act, with these terms appearing to be poorly understood and used interchangeably by some. There also seemed to be wider confusion in the language used in relation to the AWI Act; for example, a whiteboard in the staff office indicated individuals who were subject to "AWIA", however this appeared to relate only to those who had a section 47 certificate authorising medical treatment.

We were concerned about the limited level of understanding among the wider staff team on aspects of the AWI Act. We discussed this with senior staff at the end of the visit and made recommendations in relation to staff training. The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the Adults with Incapacity Act. Since our visit to the service, an eLearning module has been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16 years and older who may be considered to lack capacity to make some or all decisions. The module can be accessed [here](#).

Recommendation 3:

Managers should take steps to improve staff understanding and training in relation to the Adults with Incapacity (Scotland) Act 2000. We recommend the eLearning module on TURAS, which has been developed for informed and skilled levels of practice within the workforce.

Recommendation 4:

Managers should ensure that when a welfare proxy is in place for an individual, a copy of the document stating the powers of the proxy should be held within the care records.

Recommendation 5:

Managers should ensure that where a proxy has powers to consent to medical treatment, this person must be consulted, their consent sought; and that this process and outcome is clearly recorded.

Rights and restrictions

We saw evidence from care records that individuals continued to have access to advocacy support, and staff confirmed that Partners In Advocacy provided input on referral.

For a number of individuals on the unit at the time of our visit, English was not their first language. The team told us that there was good access to the interpreting service and that this was utilised whenever needed.

We noted positively on the last visit the information leaflets that had been developed and designed for individuals and families about the service. We asked about carer support or access to carer groups. At the time of this visit, no such support was available for carers in the service.

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 this and where restrictions are introduced, it is important that the principle of least restriction is applied. We were advised that no individuals were subject to specified person restrictions at the time of this visit. It appeared however, that there were instructions in place for the shift co-ordinator to open all mail for one individual before giving it to them in person, and this individual had not been designated a specified person. We raised this with senior staff on the day and asked that this be urgently reviewed by the team.

We suggest that managers consider MDT training in the application and use of specified persons. Our specified persons good practice guidance is available on our website: <https://www.mwcscot.org.uk/node/512>

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 mixed feedback about activities from the individuals and staff whom we spoke with.

Some individuals were positive about the range of activities available. For example, one person talked enthusiastically about cooking sessions with the OT, weekly sessions working with a volunteer from the volunteer hub and regular trips out to the local library and swimming pool.

Whilst there remained a wide range of opportunities for activities in the community and in the hospital grounds (including the HIVE, the Cyrenians Garden project and the Volunteer Hub), it appeared that for those who were less physically able, there was often less to do, particularly when staffing challenges meant there was limited availability of ward-based activities. One relative also spoke of their awareness that staffing shortages were affecting the ability to take people out.

Those from across the MDT told us that staffing had affected the provision of activities and that there were less activities and fewer opportunities to take individuals out than there had been in the past.

Individual and small group activities such as art therapy, music and cooking sessions still took place on the ward and there was a visit from a therapist every fortnight. We were told that iPads had been ordered for individuals, as well as new music equipment.

Individual timetables were developed jointly by the OT team and MDT to identify activities appropriate to each person's needs and skills. We heard there was a good relationship with the Volunteer Hub and that a number of individuals were benefitting from linking with the volunteer service.

We heard that the team were trying to increase focus on physical wellbeing and to increase people's activity levels. The unit had an adapted bike, which allowed less physically able individuals to access the hospital grounds.

There continued to be access to hospital cars and a minibus for outings, but the availability of staff to support this meant that such visits could only happen occasionally.

Concerns were widely shared with us by staff about the impact that staff shortages had on the ability to provide the level of rehabilitation that the service previously prided itself on. We heard concerns that this risked some individuals “plateauing” and “losing skills”. This was particularly notable in the case for those experiencing delayed discharge and who sometimes had a significantly prolonged stay. We were advised that the senior charge nurse was looking at each individual’s journey throughout their admission in more detail.

It was encouraging to hear that funding had been approved for an activity co-ordinator and we look forward to seeing the impact of this additional role on future visits.

Recommendation 6:

Managers should consider how the therapeutic activity within the unit can be increased and maximised, in light of the staffing challenges within the service.

The physical environment

The unit is housed in a new, modern building with many of the communal areas having an open design with direct access to internal courtyards.

The internal environment was light, bright and welcoming and remained clean and well maintained. We were told that new furniture and artworks had been ordered.

The main communal space on the ward had an area for individuals to watch television, adjacent to a space for mealtimes and group activities. The unit also had a small therapy room, with art materials and an OT kitchen.

The unit has 18 en-suite bedrooms, two of which were not in use. The bedrooms we viewed remained in good decorative condition and the spaces could be personalised when the individual chose to do so.

One of the corridors remained designated for female individuals, of whom there were four at the time of our visit. The small female sitting room in this corridor appeared to be used very little. It was disappointing to see that this space, which had been newly set up when we last visited and at that time was described as sparse, was cluttered with an excess of furniture and wheelchairs. There was no TV or access to recreational materials. It did not appear an inviting space and we were told that current individuals preferred to use the main lounge area. We were advised that a new TV and artworks had been ordered for the space.

The two internal courtyards on the unit provided access to outdoor space, which was particularly welcomed for those unable to go out into the hospital grounds or wider community. The main central courtyard had seating areas, as well as a fixed table tennis table and a pitch type area with a basketball hoop. The space appeared overgrown and somewhat neglected. However, we were told that the hospital estates team were responsible for the upkeep of the courtyards and that issues about upkeep would be raised with the management committee.

Any other comments

At the time of our visit, eight individuals – half of those in the unit - were subject to delayed discharge, meaning that they were deemed to be clinically ready for discharge, but continued

to occupy a bed, usually because of delays in securing a placement in a more appropriate setting.

Some were awaiting a care home placement in their local area, while others were on the waiting list for supported or independent accommodation appropriate to their needs.

A scarcity of resources, particularly when accommodation and support was needed in a specific locality to enable the person to live near their family, posed ongoing challenges and delays in a number of cases. The closure of a number of care homes had also added to the problem. We heard that it was becoming increasingly difficult to identify placements that would meet the complex needs of some individuals. We heard that one individual had been re-admitted to the unit following a failed discharge, which had rarely happened.

The number of delayed discharges also had a negative impact of the ability to admit individuals who required specialist assessment and treatment to this national service. At the time of our visit, three individuals were waiting to be assessed for admission to the unit.

We heard about daily meetings to review delayed discharges and follow up with social work and community services to identify suitable placements for the individuals involved.

At the time of our visit, managers in the service had just been advised by senior executives of wider changes in the health and social care partnership, which meant that management of the Robert Fergusson Unit would be moving from Edinburgh City to be hosted under the East Lothian partnership. Changes to the reporting of delayed discharges and other aspects of the service were unclear and we will monitor this at future visits.

Summary of recommendations

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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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777

Fax: 0131 313 8778

Freephone: 0800 389 6809

mwc.enquiries@nhs.scot

www.mwcscot.org.uk



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