

Mental Welfare Commission for Scotland

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

Date of visit: 22 August 2018

Where we visited

Eden Ward is a 15-bed acute assessment unit for women over the age of 65 with functional mental illness. We last visited this service on 5 October 2016 and made recommendations regarding record keeping, care plans, psychology input, and risk assessment.

Eden Ward moved to the new Royal Edinburgh Building in June 2018 along with Harlaw (formerly Eden Male Ward), the acute assessment ward for men over 65. The previous ward environments offered dormitory-style accommodation for patients. The new purpose-built wards offer single en-suite rooms for all patients.

On the day of this visit we wanted to follow up on the previous recommendations and see the new ward environment.

Who we met with

We met with and or reviewed the care and treatment of six patients. No carers/relatives/friends asked to meet with us on the day.

We spoke with the service manager, senior charge nurse, and nursing staff on the ward, as well as the consultant psychiatrist. In addition, we met with a representative from the Carers Council. Following the visit we also spoke with the advocacy service and Patients Council.

Commission visitors

Juliet Brock, Medical Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The ward had a calm, quiet atmosphere on the morning we visited. It was lively later in the day when a music group took place.

The patients we spoke with were generally positive about the care they received, but we heard some comments that staff were not always able to respond to distress as quickly as they would like. One person told us that the staff appeared very busy at times, but were approachable and spent one-to-one time when they had the opportunity.

Following the visit we spoke with both the advocacy service and with the Patients' Council. We were told there were differences in patient feedback from the male and female wards, with patients from Eden regularly expressing more dissatisfaction about

the care they receive. This included staff attitudes, patients not knowing who their keyworker was, and feeling there was a lack of information available and being shared about their care and treatment.

Recommendation 1:

Senior managers should gather detailed feedback from patients and carers about their experiences of care on the ward, addressing and monitoring any areas for improvement.

We heard concerns from advocacy agencies that some patients had recently been 'boarded out' late at night to general adult wards. This was to facilitate new admissions to the ward. We were aware at the time of our visit that senior managers were trying to address the problem of bed shortages across the hospital. In the weeks since we visited, a temporary ward has been opened to resolve this problem. We are receiving regular updates from managers about this and will continue to liaise with hospital advocacy.

The staff told us that one-to-one time with patients was one of the best things about the care they offer. On reviewing patient files it was not always clear that one-to-one sessions were taking place. We therefore repeat the following recommendation from our previous report.

Recommendation 2:

Managers should ensure staff accurately record one-to-one sessions in patients' care files to ensure clear and accurate record keeping of nurse-patient interactions.

Documentation

Currently most documentation, with the exception of Mental Health (Care and Treatment) (Scotland) Act 2003 ('The Mental Health Act') paperwork, is held in patient files in paper format. The ward are moving towards using an online system (TRAK) where notes will be accessed in the future.

In the case notes we reviewed we found admission paperwork to be detailed and comprehensive.

Where the Rapid Response Team (RTT) had been involved prior to admission, the summaries they provided were helpful and gave a good overview of the individual patient, their circumstances, and current difficulties.

Most but not all files we reviewed had a completed 'Getting to Know Me' document.

We found that nursing care plans varied in quality. Some were highly individualised, others less so. We made a recommendation about care plans following our last visit and whilst this has improved there is still room for further improvement.

We found good recording of weekly care plan reviews, which gave meaningful updates on individual patients' care.

Risk assessments were completed in all the files we reviewed.

Ward rounds take place weekly and we found these were generally well documented using the hospital's SCAMPER format. We also found evidence of good communication with carers being documented in patient files.

Multidisciplinary Team

Occupational therapy (OT) provide shared input to both Eden and Harlaw wards, providing group work and individual assessments and support.

The ward has regular input from pharmacy. Physical health issues were managed by medical staff on the ward. Physiotherapy is available on referral.

There was no dedicated support from psychology. Psychological therapy was available on a referral only basis. Staff told us they would like better access to psychology. There appears to be a particular gap in training and support in the management of stressed and distressed behaviours. In light of this we repeat our previous recommendation:

Recommendation 3:

Managers should review the need for dedicated clinical psychology input for the wards.

Use of mental health and incapacity legislation

Mental Health Act paperwork was now stored on the online TRAK system. We did not have access to this on the day.

Consent to treatment certificates (T2) and certificates authorising treatment under the Mental Health Act (T3) were present with medication prescription sheets where required.

Individuals who lacked capacity to consent to their medical care and treatment had 47 certificates in place as required.

Rights and restrictions

The door of the unit was locked to entry/exit for patient safety. There was a locked door policy. A notice is visible outside the ward about the locked door. There was no notice inside. We suggested a notice is provided inside the ward, providing explanation for patients. The senior ward staff advised they would rectify this.

Patient rooms are not locked on the ward unless individuals request this (to safeguard their belongings when they are out of their room).

Individual advocacy was provided by the hospital-based advocacy service Advocard. Support was available on referral and the Advocard team had regular contact with the ward.

Monthly meetings are held on the ward by the Patients Council.

The Commission has developed "Rights in Mind". This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at https://www.mwscot.org.uk/media/369925/human_rights_in_mental_health_service_s.pdf

Activity and occupation

The ward had no activity co-ordinator at present. Activities were provided by the OT team and by ward staff.

We heard about a range of activities on offer, from kitchen groups, gardening groups, exercise classes, and music groups to craft groups and recreational activities on the ward, such as bingo. Relaxation therapies such as hand and shoulder massage were also offered. A music therapist visited once a week.

Patients told us there were usually things happening each day. They have individualised timetables with a weekly activity schedule.

We found detailed entries from occupational therapy in patient files. It was more difficult to find information about activities in the nursing notes. If patients are unable to participate in activities or decline, this should be documented and consideration given to how to engage the patient more effectively next time.

Recommendation 4:

Ward staff should record patient participation in activities in the nursing notes, including when patients are unable or unwilling to participate.

The physical environment

The new ward environment was bright, light and spacious. The communal spaces are large and comfortable, with space to sit, talk, play games, or watch television. On the day of our visit patients were resting or engaged in activities in the lounge area and the atmosphere was calm. A separate 'quiet room' was available for patients or families if they wish for privacy.

En-suite bedrooms were spacious and well equipped. There were two larger assisted bedrooms providing facilities for wheelchair users.

Artwork on the walls had been designed around a theme chosen by staff and patients. A timetable was provided on the wall with details of activities on offer.

The ward was situated on the ground floor (compared with the previous second floor location) and had accessible garden space. The accommodation was designed around a central enclosed courtyard garden, accessible from the lounge, and dining areas.

This provided pleasant views from many areas of the ward, including the bedroom corridor, where window seating, integrated to the design, provided a number of quiet reflective spaces to sit.

The garden area was one of the most visually interesting and engaging outdoor environments the Commission visitors had seen. We were told that a number of the staff had worked in their own time to provide an enjoyable, restful space for patients and their families to enjoy. The raised beds were planted with flowers, and bird feeders and decorative elements had been introduced throughout the garden to provide interest and colour. Tables, chairs, benches, and covered seating areas provided multiple places to relax.

Both patients and staff told us how much they enjoyed the ward environment and the garden.

A shortage in storage space was the only issue highlighted by staff. This was evident by the presence of large equipment (for example an extra hoist) being stored in the assisted bathroom.

Any other comments

Delayed discharges due to delays in nursing home placements or community packages of care were highlighted by nursing staff and the consultant as a problem.

We were told that around 80 per cent of the women receiving care on the ward are discharged back to their own home with support. A smaller number require nursing home care. Delayed discharges are more frequent in the latter group.

The team do not have dedicated input from social work and liaise with locality social work teams for discharge planning. We were told this often involves delays.

Issues with communication with social work were also highlighted in an adult support and protection case in which staff lacked knowledge of the stage of enquiries. We spoke to senior ward staff about improving communication in such situations.

Recommendation 5:

Managers should address social work issues relating to delayed discharges at the appropriate level with the local authority.

Summary of recommendations

1. Senior managers should gather detailed feedback from patients and carers about their experiences of care on the ward, addressing and monitoring any areas for improvement.
2. Managers should ensure staff accurately record one to one sessions in patients' care files to ensure clear and accurate record keeping of nurse-patient interactions.
3. Managers should review the need for dedicated clinical psychology input for the wards.
4. Ward staff should record patient participation in activities in the nursing notes, including when patients are unable or unwilling to participate.
5. Managers should address social work issues relating to delayed discharges at the appropriate level with the local authority.

Good practice

We were told by staff about 'rapid rundown' meetings, which take place on four weekday mornings. These have representation from the nursing team, the consultant, occupational therapist, and the rapid response team (RRT). The meetings facilitate information sharing about patients who may need admission to the ward and those who are in the process of discharge. We were advised that the waiting list for admissions had markedly reduced since the RRT was set up, with wait time to admission usually less than two days.

We heard from both patients and ward staff that RRT input during admission was valued, with members of the team visiting patients on the ward or taking patients out for walks and outings. This benefited continuity of care.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Alison Thomson, 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 MWC 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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