

Mental Welfare Commission for Scotland

Report on unannounced visit to: Merchiston Ward, Royal
Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 8 January 2019

Where we visited

Merchiston is a 16-bedded adult acute male admission ward, with a catchment area that includes the south-west and south-east areas of NHS Lothian. We last visited this service in November 2017, along with the other three acute admission wards for the city of Edinburgh, and made recommendations relating to bed management, care planning, consent to treatment, restrictions, and the physical environment.

On the day of this visit we wanted to follow up on the previous recommendations, and look at the experience of patients receiving care in Merchiston, specifically in relation to their stay in the ward and being given information on their rights. This is because we had received information from patients and carers about these issues.

Who we met with

We met with and reviewed the care and treatment of seven patients. There were no relatives or carers that wished to meet with us on the day of the unannounced visit.

We spoke with the members of the nursing team and the senior charge nurse.

Commission visitors

Ian Cairns, Social Work Officer

Claire Lamza, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Those that we spoke to advised us that staff were informative and helpful in terms of care and treatment. We heard that patients had been provided with explanations when restrictions had been put in place, and encouraged to engage in the activities and opportunities that were available to them while in the ward.

We were also made aware that there are difficulties in transferring patients both in and out of the ward. On the day of the visit, there were patients who had been in the ward for over 12 months. Patients told us of their frustration in waiting to get a bed elsewhere as they no longer needed a more restrictive environment.

We reviewed care files, which are currently both electronic and paper-based. Daily progress notes, reviews, adverse incident, and all legal documentation are kept on the electronic record system, TrakCare. Patient pass plans, care plans, and risk assessments are paper documents.

We found the progress notes on TrakCare to be detailed. They provided a clear understanding of each patient's mental health needs, and the care and treatment they were receiving. One-to-one sessions were clearly identified, and there was evidence of engagement from other members of the clinical team, such as occupational and music therapists. We found that the SCAMPER reviews, which are the weekly multi-professional evaluations based on the patient's progress, were not consistently completed.

Recommendation 1:

Managers should ensure that the clinical team discussions, and associated actions, are detailed in SCAMPER for all patients.

While pass plans were up to date, risk assessments and the identified goals in the "my care plan" document were not. In all of the care plans we reviewed, most patients had a single care goal, and the style of writing in these was inconsistent. We found there to be a lack of definition in terms of patient goals, in the interventions that were prescribed in support of achieving the goal, and with the evaluation.

Recommendation 2:

Managers should ensure that care plan documentation is completed appropriately.

Use of mental health and incapacity legislation

On the day of our visit, for patients who were detained under the Mental Health (Care and Treatment Act) (Scotland) 2003 (Mental Health Act), we found all of the relevant paperwork located in both electronic and paper systems. We found the same for forms for consent to treatment under the Act (T2) and forms authorising treatment (T3), where a copy was kept with the medication prescription sheet.

Where a patient lacks capacity in relation to decisions about other medical treatments, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 legislation must be completed by a doctor. We discussed with nursing staff the need to keep capacity to consent to treatment under review.

Rights and restrictions

The main door in and out of Merchiston is kept locked, although there was always a member of staff to assist patients who were requesting to enter or leave the ward. We found pass plans in the care file that gave clear information about patients' time off the ward, whether this was escorted or unescorted, and the areas they were able to access. For those patients who needed to be escorted off ward, there was evidence

of this being regularly supported by nursing and occupational therapy staff. There was also access to the courtyard garden that is directly off the main day area.

We noted that, for those patients that requested it, there was involvement with advocacy and legal representation. There was also a record of patients being provided with their rights of appeal, and of being kept informed of changes in their status under the Mental Health Act. While there were no patients with advance statements, we found that the admission process prompted staff to ask patients about this routinely at the time of admission. On the day of our visit, we discussed the use of advance statements with patients that we met with, and some requested further information regarding their own statement.

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.mwcscot.org.uk/rights-in-mind/>

Recommendation 3:

Managers should ensure that patients are given information about advance statements, and supported to complete one where appropriate.

Activity and occupation

We found evidence of a range of activities for patients to engage in, although some that we spoke to said that they found that there were fewer opportunities for activities in the early part of their admission.

There is a dedicated activity co-ordinator for the ward, who works during the week and part of the weekend. While we found information that related to patients having contact with this member of staff, there was no detail provided about what had taken place during the contact or about the outcome.

Recommendation 4:

Managers should ensure that interventions provided by the activity co-ordinator are included in the care record.

We noted that the occupational therapy service provides a range of opportunities. There were comprehensive assessments, on-ward activities such as breakfast and lunch clubs, and off-ward activities such as community-based outings. We also found that patients were able to access the Hive, the gym, and the music therapist.

The physical environment

The general environment is modern and fresh, with spacious day areas and direct access onto a courtyard garden. The main corridors and day areas benefit from

artwork, information leaflets, and posters noting the range of activities available both on and off ward. There is a wall mural of the discharge tree which is part of the safe wards project.

Patients have their own rooms with en-suite facilities, with an additional bathroom for patients who prefer this option. There is access to tea and coffee making amenities and an alternative quiet space.

Patients in Merchiston who smoke are encouraged to leave the ward to do so, although we were advised that regular monitoring and prompting is required.

Any other comments

We were advised that a project is due to begin that will focus specifically on the patients experience in Merchiston Ward. This is being funded, in part, from the Patient Council and is being independently produced, with the aim of gathering the views of those who are accessing the service.

Summary of recommendations

Recommendation 1:

Managers should ensure that the clinical team discussion and associated actions are detailed in SCAMPER or all patients.

Recommendation 2:

Managers should ensure that care plan documentation is completed appropriately.

Recommendation 3:

Managers should ensure that patients are given information about advance statements, and supported to complete one where appropriate.

Recommendation 4:

Managers should ensure that interventions provided by the activity co-ordinator are included in the care record.

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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