

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Robert Fergusson Unit, Royal  
Edinburgh Hospital, Edinburgh, EH10 5HF

**Date of visit:** 18 September 2018

## **Where we visited**

The Robert Fergusson Unit is the Scottish Neurobehavioral Rehabilitation Service National Inpatient Unit. It provides inpatient rehabilitation for people with acquired brain injury whose symptoms include severe behavioural disturbance. The unit can also support patients with progressive neurological conditions, such as Huntington's disease, when specialist psychiatric care is required.

The service was previously provided across two wards (a 12-bedded male ward on the ground floor and a separate seven-bedded mixed ward on an upper floor). In January 2017 the service moved to a new purpose-built building on the Royal Edinburgh Hospital site. The ward configuration has changed, providing single en suite rooms for 20 patients in one ground floor ward.

We last visited this service on 12 July 2016 and made recommendations about the physical environment and documentation relating to the Adults with Incapacity (Scotland) Act 2000 ('The AWI Act').

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

## **Who we met with**

We met with and/or reviewed the care and treatment of nine patients. We also met with the relatives of three patients.

We spoke with the senior charge nurse and both consultant psychiatrists. In addition we met with the occupational therapist, art therapist, speech and language therapist, a number of members of the nursing team, and health care assistants.

## **Commission visitors**

Dr Juliet Brock, Medical Officer

Moira Healy, Social Work Officer

## **What people told us and what we found**

### **Care, treatment, support and participation**

Some patients we met were more able to speak with us than others. Those who could tell us about their experiences on the ward commented positively on the care they received from staff. Lack of activities and boredom was however a common experience that patients shared with us.

The carers we met with were also generally positive about the care their relatives were receiving. However, lack of activities due to staff shortages was raised by carers as a concern.

The central issue raised with us throughout this visit (by patients, their relatives, and consistently by the many professionals we spoke with) was the impact of current staffing levels on patient care.

The staff team explained the issue as being threefold.

#### **1. Reduction in staffing numbers**

The number of patient beds increased from 19 to 20 when the service moved. Since transfer to the new unit, occupancy had not exceeded 18. On the day of our visit there were 16 inpatients and the ward had four empty beds. We were advised there was a waiting list of three patients awaiting transfer from other health board areas, but that admissions could not be facilitated within current staffing levels.

#### **2. Environment**

The new unit was designed to enable the two wards to be amalgamated. It was anticipated that this change would enhance patient care, allowing the whole staff team to work together with patients across a single clinical area. Staff told us that the new environment had proved more challenging to provide care for patients than the previous two wards. In the new configuration, communal areas and bedroom corridors are spread over a large footprint. The bedroom corridors are not easily visible from a central point and are difficult to supervise. Staff told us it was difficult to monitor and support patients across this space.

To address this, the nursing team split into two smaller groups to cover different areas of the ward. The staff told us this enabled them to better care for patients across the ward environment, but that this remained a challenge.

#### **3. Enhanced observations**

The unit provides the only inpatient NHS service for neurobehavioural rehabilitation in Scotland. The staff team told us that patients were being referred with increasingly complex physical and mental health needs and associated risks, and often require

enhanced levels of observation (one-to-one or two-to-one nursing care). At the time of our visit, four patients were on long term enhanced observations.

In addition staff are supporting patients who may have significant physical disability and personal care needs, requiring very high levels of nursing care.

Staff and carers also shared concerns about safety issues on the ward and a number of carers told us they were making complaints in relation to concerns about staffing levels.

We were informed of recent incidents involving both patients and members of staff. We were told the incidents were not directly linked to staffing levels and were being investigated. We will follow up outcomes with senior managers.

The staff told us they currently prioritised patient safety and the management of individual behavioural and physical/personal care needs. Both staff and carers told us that for many patients, their rehabilitation needs were not currently being met. We were told that a workforce planning tool was recently completed by the team and currently under review by managers.

### **Recommendation 1:**

Managers should review current staffing requirements for the service. The staff team should be able to meet the physical, behavioural, and rehabilitation needs of all patients at the Robert Fergusson Unit, and to do so safely within the new ward environment.

In spite of the current challenges, we found a team who were supportive of each other, who were committed to patients, and were working together to provide the best level of care they could.

We found that staff had detailed knowledge about the patients in their care and the complexity of each person's needs. When we asked about the best aspects of care the staff provide, the response was that the team offered highly person-centred care, viewing each patient as an individual and supporting them with a high level of respect and dignity.

Staff members spoke with us about the level of progress some patients had achieved on the unit with rehabilitation support and how rewarding they found this work.

### **Multidisciplinary Input**

The service provides a multidisciplinary approach to patient care. There was dedicated support from occupational therapy (OT), speech and language therapy, physiotherapy, and art therapy. Psychological therapies are led by consultant neuropsychiatrists with specific training and expertise to deliver psychotherapies directly; coordinate team based therapy and supervise and train other staff in their delivery.

There are two social workers who liaise with patients own health boards to help plan accommodation/support needs on discharge.

We were told that one of the Band 6 charge nurse roles had also recently been developed to provide outreach, supporting patients who were preparing for discharge. By working with community staff, the outreach nurse helped to provide continuity of care for patients during the transition from hospital to home. We were told this new role was working well. Due to current staffing issues, the outreach nurse was frequently used to support colleagues on the ward.

### **Multidisciplinary review and documentation**

We found patient notes were well organised and documentation was easy to find.

'Getting to Know Me' documents were present and generally well completed.

In the files we viewed, nursing care plans were excellent. They were divided into 'progressive support plans' and 'maintenance support plans'. Care plans were highly personalised and provided meaningful detail about the patient and how staff could best support them with each aspect of their care. Where individual patient needs were highly complex, for example around challenging behaviour, this was reflected in the care plans.

We found that the 'current focus' document was also well used. This highlighted areas of each patient's care that the team planned focus on during a six week period.

Ward rounds and reviews were well documented with clear decision making and plans.

### **Use of mental health and incapacity legislation**

In the patient files we viewed, we found that documents relating to Mental Health (Care and Treatment) (Scotland) Act 2003 ('The Mental Health Act') and the AWI Act were present where appropriate. It was not immediately easy to see what powers and restrictions were in place however. We suggested that a front sheet be introduced to this section of the notes to provide a summary that could be viewed at a glance. This was discussed during feedback on the visit and senior staff plan to take this forward.

Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required.

AWI Act section 47 consent to treatment certificates were in order along with accompanying care plans where required.

### **Rights and Restrictions**

Both staff and relatives raised concerns about increased restrictions being placed on patients due to the nature of the new ward environment and current staffing levels. They advised that patients weren't getting out as much as they had on the previous

ward. One carer told us they facilitated regular outings to ensure there was opportunity for their relative to engage in recreation and activities outside the ward.

A visitor raised concern about restrictions being placed on an individual patient and we raised these issues with the team on the day and will follow this up.

### **Recommendation 2:**

Managers should ensure that staffing levels are adequate to facilitate passes for those patients who need a staff escort to leave the ward.

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>

### **Activity and Occupation**

Lack of activity and meaningful occupation on the ward was a concern raised by patients, by relatives, by the nursing team and other members of the multidisciplinary team.

This was a clear change since we last visited, when we found a strong emphasis on socialisation in patient care plans and saw people being escorted off the ward to participate in activities such as walks, outings in the minibus, shopping, and meals out. The OTs continue to offer activities on a one to one basis or in small groups. They are able to support some patients in accessing activities outwith the ward, such as the gardening project and volunteering opportunities. They highlighted that staff can no longer regularly facilitate outings, such as group visits to the cinema or to go shopping.

We were told that there was currently insufficient support to the OT programme to develop patient skills, socialisation and independence.

### **Recommendation 3:**

Managers should review the current provision of rehabilitation-focussed activity on the ward.

### **The physical environment**

The new building housing the Robert Fergusson Unit provides a bright and light ward environment. The ward and clinical spaces are all provided on the ground floor, with office and meeting spaces upstairs.

En-suite bedrooms are spacious, well furnished and can be personalised where patients wish to do so.

The ward has been configured to provide a small female-only corridor with four bedrooms and a designated female sitting room where patients can relax, watch television or eat meals separately if they wish. The sitting room was small, somewhat sparsely furnished and realistically accommodated only a few people at once.

The corridors surrounding central courtyard offer quiet seating areas to view the garden spaces. The main enclosed garden area provides permanent, fixed equipment for table tennis and for outdoor physiotherapy, as well as seating areas.

As highlighted previously, a concern highlighted by staff was the lack of clear visibility to the bedroom corridors, some of which are at a distance from the main communal area. = Whilst the Commission have given advice on this, we would not support assistive technology (CCTV) being used as an alternative to providing adequate staffing levels.

The main communal space, comprising lounge and dining area separated by a partition unit, was surprisingly small. The seating in the lounge area comfortably accommodates around half of the patient group. There is limited space for manoeuvring wheelchairs. Similarly, the dining area comprised several small tables with limited space for staff to support those with mobility needs. We were told there were plans to remove the partition to open out the communal space.

We found the communal area to be noisy. Staff from across the disciplines commented on the problem of noise on the ward and the stress this could cause patients and raised concerns about the environment at mealtimes being 'overwhelming' for some patients due to sensory overload.

We have visited other units where environmental adaptations have been introduced to ameliorate the problem of excessive noise. We discussed this with staff on the day.

In general, we found the appearance of environment to be rather sparse and clinical. On other newly built wards we have visited in the hospital we have seen pictures, murals, objects, books and film collections providing focal interest and engagement for patients. We recommended that the staff team look at ways of enhancing the environment in this regard.

#### **Recommendation 4:**

Managers should review the issue of excessive noise levels on the ward and consider what environmental adaptations can be made to reduce this problem.

#### **Other Issues**

##### **Delayed discharge**

We were advised that eight of the sixteen patients on the ward were identified as having a delayed discharge at the time of our visit. This is kept under review by

managers and discussed with other authorities. The Commission should be provided with an update on the status of all delayed discharges from the unit.

## **Summary of recommendations**

1. Managers should review current staffing requirements for the service. The staff team should be able to meet the physical, behavioural and rehabilitation needs of all patients at the Robert Fergusson Unit, and to do so safely within the new ward environment.
2. Managers should ensure that staffing levels are adequate to facilitate passes for those patients who need a staff escort to leave the ward.
3. Managers should review the current provision of rehabilitation-focussed activity on the ward.
4. Managers should review the issue of excessive noise levels on the ward and consider what environmental adaptations can be made to reduce this problem.

## **Good Practice**

A small number of staff from the service have helped to create an online resource providing information on acquired brain injury. This has been done in collaboration with the Scottish Acquired Brain Injury Network (SABIN), who host the e-learning resource on their website. This resource – which is accessible to all – provides information on brain injury, on individual symptoms and strategies to help manage them. It is designed to offer information and support to patients, families and professionals. As the resource is Scottish-based, it also has information relating to relevant legislation in Scotland. We were told that this new resource has been very positive.

## **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.

**Contact details:**

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

telephone: 0131 313 8777

e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

