**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Margaret Duguid Unit, Royal Edinburgh Hospital, Morningside Place, Edinburgh EH10 5EF

**Date of visit:** 14 March 2022

## Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

The Margaret Duguid Unit is a four-bedded ward in the Royal Edinburgh Hospital. The unit occupies a former ward on the hospital site, which was refurbished for its current purpose. It opened as the Margaret Duguid Unit in 2020. The unit provides support and rehabilitation for individuals who require a high level of care due to complex mental health needs and challenging behaviours. The service is also designed to support patients who have additional physical health needs or physical frailty.

The opening of the unit enabled some patients, who were receiving out-of-area care in other health boards (for example individuals previously requiring low secure forensic mental health provision, which NHS Lothian does not provide), to return to their local area.

Before the unit opened, the Commission carried out an informal visit to meet with staff and to view the environment. During the early stages of the pandemic, we maintained contact with managers to discuss the impact of Covid-19 on hospital services and were made aware that the unit was designated for the care of Covid-19 positive patients, if this was required.

This visit in March 2022 was the first Commission visit to meet with patients on the new unit and to review their care and treatment.

On the day of this visit there were no vacant beds. One patient who had tested positive for Covid-19 on another ward had been moved into the unit temporarily, for a period of isolation.

## Who we met with

We met with, and reviewed the care of, three patients. We spoke with the clinical nurse manager, the consultant psychiatrists and members of the nursing team.

## Commission visitors

Juliet Brock, medical officer

Claire Lamza, executive director (nursing)

# What people told us and what we found

## Care, treatment, support and participation

The patients we spoke with had different levels of ability to give us feedback on their experiences. We heard some positive comments about staff and the care being provided and we heard that for some, the space and layout of the ward was beneficial for them. We observed supportive interactions between staff and individual patients during this visit.

### Multidisciplinary team (MDT)

The unit had a multidisciplinary team (MDT) consisting of nursing staff, psychiatrists and occupational therapy (OT) staff. We heard that there was input from an art therapist and music therapist and that funding had been granted for all rehabilitation wards in the hospital to receive art and music therapy. We were advised that a psychology post was being recruited to at the time of our visit. This post would provide dedicated psychology support to the unit three days a week. Referrals are made to all other services, such as the dietician, physiotherapy and speech and language therapy, as and when required.

### Care records

Information on patients care and treatment was held mainly on electronic record system TRAK, with additional information remaining on paper files.

The daily nursing entries on TRAK used a clear format to provide updates on individual patient care. There was good evidence of one-to-one nursing interventions, medical reviews and input from other disciplines. Participation in activities was recorded by ward staff and OTs, as were times when activities were offered but the patient declined to engage.

We saw good attention to patient's individual physical health needs, with input to the ward from external specialists and transfer for medical care when this was required. One patient required a specialist wheelchair and we noted there had been an unfortunate delay in acquiring this.

MDT discussions and decisions were well-documented, as were three to six-monthly reviews, which were recovery-focussed and included individual formulation. We noted the team used a rehabilitation integrated care pathway for patients.

### Care plans

Nursing care plans were uploaded onto TRAK, where the current format is heavily focused on physical health needs. This has been an issue highlighted by multiple mental health teams across the hospital. Care plans should be person-centred and address the full range of care needs for the mental health, physical health, and more general health and wellbeing of the individual. Managers have advised the Commission that work is underway to revise electronic care plan design for mental health settings, to implement a format better suited to the needs of patients in mental health services. We await the outcome of this work with interest. In the interim, we noted that existing nursing care plans were regularly reviewed.

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

## Use of mental health and incapacity legislation

On the day of our visit, some of the patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). Where it was possible to establish, those that we met with during our visit had a fair understanding of their detained status, where they were subject to detention under the Mental Health Act. Documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 2000 (AWI), including certificates around capacity to consent to treatment, were in place.

## Rights and restrictions

At the time of this visit, there were still some restrictions on hospital visiting due to the Covid-19 pandemic. Patients were allowed one visitor per day. We heard that visits from family members were being accommodated on the ward and patients were being supported to maintain contact with friends and family.

When reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act, which are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility to promote advance statements. We could not find copies of advance statements within the notes we reviewed, however believe at least one of the patients on the ward had opted to make one.

**Recommendation 1:**
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this. These discussions should be clearly documented in the patient's clinical notes along with a copy of any advance 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/law-and-rights/rights-mind

## Activity and occupation

There was a good level of OT input during the week and patients were often offered individual sessions to suit their specific needs. There was no dedicated activity co-ordinator on the unit, but we were told this was incorporated into the role of Band 3 staff.

Two of the patients we spoke with talked enthusiastically about the activities they participated in. There was input to the ward from a music therapist one day a week and we heard positive feedback about one-to-one sessions tailored to each patient's personal preferences and abilities. We also heard positive feedback about art therapy sessions offered on the ward.

Each patient had a weekly timetable devised by the occupational therapist and we heard from patients about weekly outings and additional activities tailored to their individual interests. It was evident that activities focused on therapeutic aims, as well as building social skills and,

for some individuals, developing confidence in aspects of daily living such as shopping, cooking and doing laundry. Patients on the ward have access to an OT kitchen and we heard about meal planning and cooking sessions supported by the OT.

## The physical environment

The unit was a refurbished traditional ward, with the layout configured along a single corridor, with patient bedrooms, communal areas and staff rooms accessed directly off this.

Whilst the environment was clean and well maintained, overall the communal spaces had a rather sterile, clinical feel. The lounge/dining area was quite bare and uninviting. At the time of our visit the small sitting room was empty and the family room was being used as a store room. At the end of the ward there was access to a shared courtyard space, which some patients used as a smoking area.

The bedrooms we viewed were spacious, with en-suite shower rooms. Patients were able to personalise their bedroom space and we saw evidence of this. One patient told us their en-suite room was “a delight” compared to a previous ward. There was also an assisted bathroom on the ward for those preferring to use a bath.

We would encourage the staff team to work in collaboration with the patient group to consider improvements that might be made to the ward environment, for example with artworks and furnishings, to make the communal spaces more comfortable and inviting.

## Any other comments

We heard from the team that staffing was a challenge and that the unit was currently providing a service with less than the full complement of trained nursing staff. The Commission is aware that this issue is a widespread challenge for services not only across the Royal Edinburgh Hospital but across mental health services in Scotland. Senior managers in NHS Lothian have advised of initiatives that have been put in place to improve the recruitment and retention of mental health nurses in the health board. Given the current impact of staffing shortages (both medical and nursing) on mental health services across the country, we will continue to monitor this issue closely through our local visit programme and other activities.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that staff are familiar with their role in promoting the use of advance statements and providing patients with information and assistance with this. These discussions should be clearly documented in the patient's clinical notes along with a copy of any advance statement.

## Service response to recommendations

The Commission requires a response to this recommendation within three months of the date of receiving this report.

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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