Mental Welfare Commission for Scotland

Report on announced visit to:

Pentland Ward, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh, EH10 5HF

Date of visit: 7 June 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt its 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.

Pentland Ward is an eight-bedded ward for men with organic mental illness who have complex care needs. Whilst predominantly providing hospital based complex clinical care (HBCCC) care for men over the age of 65 with dementia, younger patients with early onset dementia or those with mental health difficulties as a result of chronic neurological disease (such as Huntington's), may also receive care on the ward.

The ward was previously situated on the ground floor of the Jardine Clinic, in the grounds of the Royal Edinburgh Hospital (REH). When we visited in 2018, Pentland was the only ward open in the Jardine Clinic at that time and we were informed of plans to refurbish the building. In December 2019 the Commission was advised that Pentland had been decanted temporarily to another ward, formerly Comiston Ward, to facilitate the required renovation work. Patient numbers had been reduced from 14 to eight to accommodate this move. Comiston Ward, previously an in-patient rehabilitation ward for older adults, had been vacant after the in-patient service closed. As one of the older wards in the Royal Edinburgh Hospital, prior to its closure, the Commission raised concerns on visits to Comiston Ward about the suitability of the environment for in-patient care. The temporary relocation of Pentland Ward to this setting was planned for a period of three months, however, when we last visited the service on 8 December 2020, Pentland Ward had remained housed in Comiston for 12 months. This was primarily due to building works to renovate the Jardine clinic being delayed due to the onset of the Covid-19 pandemic. On the last visit, we were told there were no imminent plans for relocation to the Jardine Clinic, or proposed timescales for this to happen. In our last visit report we raised serious concerns about the ward environment and made recommendations for action to urgently address this. We sought updates over the following eighteen months, but were advised there had been no progress. The staff team continued to share concerns about the environment.

On the day of this visit we wanted to look again at the ward environment and to find out if there had been any further progress made toward the previous recommendation. We were also keen to hear from patient, carers and from staff about their current experiences.

On the day of this visit there were six patients and one vacant bed. We were advised that patient numbers had been capped at a maximum of seven so that no patients were sharing a bedroom.

We have since been advised that following on from our visit to Pentland, due to an urgent environmental issue on the ward, the patients and staff were moved temporarily to another ward in the hospital. In November 2022, due to ongoing staff shortages across older peoples services in the hospital, the decision was made to amalgamate Pentland Ward with Canaan Ward, a male dementia assessment ward in the new Royal Edinburgh Building. The

Commission visited the newly amalgamated ward in January 2023. The report of this visit will be published in the coming months.

Who we met with

We reviewed the care of all six patients on the ward. We also spoke with two relatives.
We spoke with the senior charge nurse, the lead nurse and the psychologist.

Commission visitors

Juliet Brock, medical officer
Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

The patients on the ward were not able themselves to tell us about their experiences, but our observations were that the ward was calm, the staff were caring, patient, and attentive towards the patients and had a detailed knowledge of the support needs of each individual. We observed patients interacting with staff and participating in activities on the ward.

Talking to staff, there was an emphasis on positive behavioural support when patients were in distress and we were told that there was very little use of as-required medicine on the ward. We got the impression of a positive ward culture and therapeutic ethos.

The carers we spoke with told us that the staff were very caring and helpful. They felt welcome on the ward and said that communication about the care of their relative was generally good.

Multidisciplinary team (MDT)

The ward had an MDT on site consisting of nursing staff, visiting psychiatrist, occupational therapy and input from a psychologist one day a week.

Input from physiotherapy and speech and language therapy can be requested on an individual bases and we were told that services were very responsive, with referrals usually being answered in one to two days.

The ward staff were very positive about psychology support, particularly in developing individual formulations and behavioural plans to support patients with stress and distress. As the psychologist also worked on Canaan Ward, from where all patients were transferred, we were told they were able to follow patients on their journey through the hospital, providing continuity of care.

Care records

Care records were mainly held on the hospital electronic record management system, TRAKcare. Daily care notes used electronic prompts from the patient care plan format. This meant that not only was physical health and personal care documented, but there was meaningful recording of the patient's mental state during a shift. This brought richer detail and meaningful content to the everyday records, including the overnight notes. We did however note that there was limited written record of patient participation in activities, except for some OT entries. We thought this could have been improved.

The MDT meeting notes often lacked detail, record of discussions and clear action plans. We felt these could have been more comprehensive.

Care plans

We found excellent examples of nursing care plans. We noted evidence of psychology input in the development of individual patient formulation and it was clear that this then informed stress and distress care plans, which were person-centred and highly detailed, especially in relation to how staff could best practically support the individual when in distress. There was a good balance of care plans for both patient's physical, mental health and personal care. We

also saw clear evidence of regular care plan reviews and examples of this being done in discussion with family.

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:
Managers should ensure that MDT meeting records clearly document attendance, discussions, decision taken and record patient and/or relative participation.

Use of mental health and incapacity legislation

On the day of our visit, five of the six patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, but we found some medications that had been prescribed but were not properly authorised by the T3. We discussed this with senior staff at the end of the visit

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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 section 47 certificates in place for each patients, but one required review.

For patients who had covert medication in place, appropriate pathways were in place, however these were not being reviewed within the timeframe initially specified by the clinical team.

The Commission has produced good practice guidance on the use of covert medication: https://www.mwcscot.org.uk/node/492

Recommendation 2:
Medical staff must ensure the required legal authority for treatment is in place for all patients who are subject to the Mental Health Act or AWI Act. When a patient has a T2 or T3 in place, the responsible medical officer must ensure that any newly prescribed treatment is properly authorised.

Rights and restrictions

The ward operated a locked door policy, commensurate with the level of risk identified with the patient group.

We were advised that referral can be made for independent advocacy support from Partners in Advocacy.

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

We heard that the activity co-ordinator had left the post a few weeks prior to the visit. Although it appeared to us that patients were participating in activity on the day of our visit, one carer was concerned that there did not appear to be enough activity on the ward, in comparison to when their relative had been in Canaan Ward.

We were told there was a commitment from senior managers to replace the activity co-ordinator post and we welcomed this. It was notable that feedback about activities on our previous visit to the ward had been very positive.

We were told that OT input was minimal, as this support had been focussed on assessment wards. However, a six-week pilot was underway at the time of this visit to focus on one-to-one OT support for patients on the ward, with a focus on sensory work. There was also input from a music therapist, with a 'Music in Hospitals' initiative due to recommence the following month.

The physical environment

The ward is housed in one of the older parts of the hospital and does not provide the purpose-built single rooms and en-suite facilities available for patients in the new Royal Edinburgh building. Bedrooms were small and the shared toilet and bathroom facilities were cramped.

Details about the ward layout and issues with this were raised in the Commission's previous reports. On this visit ward staff continued to raise concerns with us that the environment was not fit for purpose and was unsuitable for the patient group.

We did note some cosmetic improvements on this visit, with freshly painted walls, more artwork on display and dementia-friendly signage.

We raised concerns on the visit about the continued lack of suitability of the environment for the patient group.

As outlined in the introduction of this report, patients are no longer housed on this ward and are now cared for in Canaan ward, which provides en-suite facilities in a bright modern environment with direct access to safe and accessible outdoor space. The environment on Canaan ward is much better suited to the needs of this patient group.

Summary of recommendations

Recommendation 1:
Managers should ensure that MDT meeting records clearly document attendance, discussions, decision taken and record patient and/or relative participation.

Recommendation 2:
Medical staff must ensure the required legal authority for treatment is in place for all patients who are subject to the Mental Health Act or AWI Act. When a patient has a T2 or T3 in place, the responsible medical officer must ensure that any newly prescribed treatment is properly authorised.

Service response to recommendations

The Commission requires a response to these recommendations within three months 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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