Mental Welfare Commission for Scotland

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

Date of visit: 17 October 2023

Where we visited

Blackford Ward is the intensive psychiatric care unit (IPCU) for the City of Edinburgh, including East Lothian and Midlothian. It is a 10-bedded, mixed-sex unit with a separate high dependency suite. IPCUs provide intensive treatment and interventions to patients who present with an increased level of risk and require a more individualised, intensive level of observation. This type of unit generally has a higher ratio of staff to patients and a locked door. It would be expected that staff working in IPCUs have particular skills and experience caring for acutely ill and often distressed patients.

We last visited this service on 23 April 2021 and made recommendations in relation to managers developing a smoke-free environment and the inclusion of occupational therapists (OT) in the multidisciplinary team (MDT).

On the day of this visit we wanted to follow up on the previous recommendations and meet with the patients, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on the ward.

Who we met with

We met with six patients in person and reviewed five sets of care notes. No relatives/carers requested to meet with us.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), responsible medical officer (RMO), medical staff, nursing staff, art therapist and the activity co-ordinator.

In addition, we made contact with AdvoCard, advocacy services and the Volunteering Hub.

Commission visitors

Kathleen Liddell, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Comments from patients

The patients we met on the day of the visit were mainly positive about their care and treatment in Blackford Ward. The feedback included comments such as, “the best staff I have worked with”, “staff are caring and give me their time” and “I feel listened to”. Some patients told us that they had a key nurse who they met with regularly and valued this one-to-one interaction. Other patients were unaware of who their key nurse was.

All of the patients we met with told us that they had regular contact with medical staff and regular review of their physical and mental health care needs.

Many of the patients spoke highly of the activity co-ordinator and activities available on the ward. Art therapy and activities related to music and therapet were also viewed as positive by many of the patients we spoke.

Most of the patients we met with were not aware of their care plan, adding that they had not been involved in the compilation of it. Some of the patients told us that they did not always feel involved in decision making and would like to be given the opportunity to attend the weekly MDT meeting.

Some patients told us that they felt there were gaps in their care plan in relation to opportunities to engage with an OT. One patient told us that they wanted to develop skills in cooking and use the OT therapy kitchen in the ward however, there was no OT based in the ward and no access to the therapy kitchen.

We did not speak with any relatives or carers on the day of the visit. We were told by staff that the ward ran a carers support group alongside VOCAL Edinburgh Carers service. The group was an opportunity for relatives and carers to share their experiences and be provided with support to enable them to carry out their caring role.

The SCN told us that a carer’s charter was being developed by staff and carer representatives, to support the role of the carer and provide essential information to carers, in relation to support available when their relative is an inpatient.

Staff that we spoke with knew the patient group well and appeared committed and motivated to support the patients. It was encouraging to hear that staff time was prioritised to allow them to spend time with patients on a regular basis to support building therapeutic relationships.

Care, treatment, support and participation

Nursing care plans

Nursing care plans are a tool that identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We reviewed the care plans and risk assessments that were stored electronically on TRAKcare. We found the care plans in Blackford Ward to be of mixed quality. From the files

we reviewed, patients tended to have four care plans recorded in relation to mental state, physical health needs, violence and aggression, and activity/occupation. For patients who engaged in art therapy, we saw art therapy care plans. We were pleased to find that some of the care plans, mainly the activity and art therapy care plans, were individualised, person-centred, evidenced strengths-based goals and outcome-focussed interventions. Other nursing care plans we reviewed did not have the same level of quality and were mainly didactic, generic with little evidence of personalised care or clear detail on the purpose of the nursing intervention recorded. For example, we found many care plans that recorded an intervention to support the patient such as, 'use of distraction techniques' however, the care plans lacked detail as to what the specific intervention entailed.

None of the patients we met with had a copy of their care plan or had been actively involved in the compilation and review of their care plan. Most patients were not aware they had a care plan. We did not find evidence of relative/carer involvement in the care plans we reviewed. Some of the patients we met with were clear that they did not want their families involved in their care plan. We heard however, that where appropriate, families had some involvement in care planning and had provided information to staff from their perspective as a relative/carer to the patient.

We found evidence of regular care plan reviews taking place. Some of the reviews provided a good level of detail on patient progress and areas of care that required ongoing support. Other reviews did not record robust information about the targeted nursing interventions and the individual's progress.

We found the risk assessments to be comprehensive and of a good standard. The risks were clearly recorded with a plan to manage each identified risk.

We saw that physical health care needs were being addressed and followed up appropriately by core trainee medics. The medical reviews completed by the core trainees were of a high standard. The reviews undertaken by them included comprehensive information that was personalised and included forward planning for care and treatment.

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 nursing care plans are person-centred, containing individualised information reflecting the care needs of each person, and identify clear interventions and care goals.

Care records

During our visit, we looked at the patients' information that was held electronically on the IT system TRAKCare. We found the care records to be mainly of good quality. The consistent used of canned text by staff supported a good level of detail in the care records. We found many examples of care records that recorded comprehensive and personalised information that included what the patient had achieved and aspects of the day which had been difficult.

Some care records used language such as, 'evident on the ward' and 'low profile'. This use of language does not provide information on the patient's current issues or staffing interventions.

We saw evidence of one-to-one interventions between nursing staff and patients. The recording of the one-to-one interventions were comprehensive and included information on patients' views in relation to their care and treatment.

We were pleased to see comprehensive care recording from various members of the MDT. In particular, the care records from medical staff were of a high quality. We were impressed by the regular review of patients' mental health by the consultant psychiatrist and ST6 (a doctor in their sixth year of speciality training). The care records we reviewed were thorough, person-centred and evidenced a rights-based approach.

As expected for an IPCU patient population, the care records we reviewed evidenced high levels of clinical acuity. Patients required intensive treatment, interventions and high levels of observation. The patient group could experience high levels of stress and distress leading to increased clinical risk due to high levels of verbal, physical aggression and self-harm. We were pleased to note that the MDT were actively involved in providing the support, care and treatment to patients at these times.

We heard from staff that since the last visit, there were higher levels of patient clinical acuity on admission to IPCU. We heard from patients and saw from our review of their files, complex and challenging admission circumstances. We read that for one patient, a warrant under section 35 of the Mental Health (Care and Treatment) (Scotland) Act 2003 had been granted and a medical examination undertaken that concluded IPCU care and treatment was required. Due to a shortage of ICPU beds across Scotland, the patient had to remain at home in difficult circumstances. As a result of the time delay in identifying an IPCU bed, the warrant lapsed and a further warrant had to be applied for. The patient found this experience traumatic and detrimental to their health, safety and well-being.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. In addition to medical and nursing staff, the MDT was made up of an activity co-ordinator, pharmacy and art therapy. We also heard that the ward had regular input from phlebotomy and spiritual care services. It was positive to hear that a trainee advanced medical practitioner (AMP) for acute services would be available imminently to support assessment and review of physical health care needs. There was no psychology based in the ward. We were told that when psychology input was required, a referral is made to psychological services.

A recommendation was made in the previous report in relation to OT being part of MDT. We were told that following the last visit, an OT was employed directly from the ward budget, and was line managed by the SCN and based in the ward. We heard this was beneficial for patients as the OT was fully integrated into the MDT and involved in discussions and decisions regarding all aspects of risk assessment and care planning. We heard the OT intervention provided individualised and person-centred assessments that supported a holistic approach to the patients' care and treatment in the ward. The OT left post six months ago and had not been replaced by acute OT services. We were told that if OT input was required, a referral

should be made to OT acute services. We heard that this arrangement had been problematic, mainly due to the associated risks factors for patients who meet the criteria for IPCU and a view from the OT service that the risks were too high to manage. The SCN told us that when the OT was integrated into the MDT, there was a greater understanding of the patient's needs and assessed risks factors. We are aware from visiting other services in the Royal Edinburgh Hospital that some wards have OT integrated into the MDT and noted the lack of parity across all mental health services in the hospital. We heard from some patients that they would benefit from regular OT involvement, especially in relation to developing cooking skills and having access to the therapy kitchen in the ward, which was not being used.

The MDT meeting was held weekly in the ward. In attendance at the meeting were medical staff, nursing staff, pharmacy and at times, art therapy. The MDT meeting was recorded on TRAKCare on a mental health structured MDT meeting template. The template had headings relevant to the care and treatment of the patients in Blackford Ward. We found comprehensive and detailed recording of the MDT discussion and decisions that promoted a holistic approach to the patient's care. There was evidence of discharge planning for some of the patients we reviewed. For these patients, there has been communication with community teams and services to support discharge planning.

It was evident from review of the MDT records and from discussions with patients, that patients did not attend the MDT meeting. We were told, and saw from review of care records, that the RMO met with the patient prior to and following the meeting to discuss their care plan, ascertain their view and to discuss the outcome of the meeting and decisions made. Feedback from many of the patients that we met was that they would like to either attend the meeting or have the option of attending. Some patients raised that they did not feel involved in decisions and discussions regarding their care and treatment. Other patients were happy with the current arrangement.

In relation to carer/relative involvement, we heard and saw that when family were involved with a patients' care, separate family meetings were arranged.

We discussed with the CNM, SCN and RMO the importance of promoting the principle of participation and supporting the patient to participate as fully as possible in any decisions made. The RMO and SCN agreed that given the feedback from the patients during the visit, a review of the current MDT meeting arrangements would be undertaken to consider how patient participation could be increased.

Recommendation 2:
Managers should review the occupational therapy provision in Blackford Ward to ensure greater equity of occupational therapy provision across the Royal Edinburgh Hospital services.

Use of mental health and incapacity legislation

On the day of our visit, all 10 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. We found the forms relating to each patient's detention stored electronically on TRAKCare.

The patients we met with during our visit had a good understanding of their detained status under the Mental Health Act. Some of the patients we met with had a mixed understanding of their rights if they were detained. However, we were pleased to note from the files we reviewed that there was evidence of legal representation and advocacy involvement to support patients understand their legal status and exercise their rights.

During discussion with the patients, staff and advocacy services, and from our review of the patient files, we noted that some of the patients who were subject to a short term detention certificate (STDC) did not have an allocated mental health officer (MHO). For some patients, MHOs had not been allocated, following the granting of the STDC that had taken place 14 days previously. One patient raised that they wanted to nominate a named person and one patient wanted to change their named person however, neither been given the opportunity to discuss this with an MHO. The Mental Health Act is clear that the local authority must ensure that an MHO is designated "as soon as it's reasonably possible" as responsible for the case of any person in respect of whom a "relevant event" (as listed in section 232 of Mental Health Act) has taken place. A "relevant event" includes the granting of a STDC. We were concerned that many of the patients we met with did not have an allocated MHO and we would view 14 days as an unacceptable amount of time for the local authority to designate one.

MHOs have specific duties and responsibilities set out in the Mental Health Act following the detention of a patient. Given the delay in allocation of an MHO, we were concerned these duties were not being fulfilled, for example in relation to the nomination or revocation of a named person. Although it is the collective responsibility of the MDT to discuss and promote rights with patients, we were concerned that for patients who did not have an allocated MHO, it negatively impacted on the ability to provide rights-based care, where the patient did not have access to an MHO's specialist skills and knowledge.

Part 16 (sections 235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion by an independent designated medical practitioner (DMP) for certain safeguarded treatments and the authorisation of medications prescribed beyond two months, when the individual does not consent to the treatment or is incapable of doing so. Treatment must be authorised by an appropriate T3 certificate, or a T2 if the patient is consenting.

We reviewed the prescribing for all patients, as well as the authorisation of treatment for those subject to the Mental Health Act. We found one patient had as required medication prescribed which was not authorised by their T3. We highlighted this issue on the day of the visit and measures were taken by the clinical team to rectify this immediately.

Medication was recorded on the electronic prescribing system HEPMA (hospital electronic prescribing and medicines administration). T2 and T3 certificates authorising treatment were stored separately on TRAKcare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the ease of checking that the correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason, we suggested during the visit that a paper copy of all T2 and T3 certificates be kept in the ward

dispensary, so that nursing and medical staff have easy access to, and an opportunity to review, all T2 and T3 certificates. The RMO and SCN were of the view that a paper copy of all T2 and T3 certificates was not required and the system in place was effective for dispensing treatment under the correct legal authority.

Recommendation 3:
Managers should urgently ensure a pathway is developed in partnership with social work colleagues to support timely allocation of an MHO for detained patients.

A copy of this report will be sent to City of Edinburgh Council senior social work managers.

Rights and restrictions

Blackford Ward continued to operate a locked door, commensurate with the level of risk identified with the patient group.

Most of the patients we met with had good knowledge of their rights. We saw that each detained patient received a letter from medical records following detention under the Mental Health Act that including information on their detained status and their rights in relation to this. We found that some patients had exercised their rights and appealed their STDC.

Given the high clinical acuity levels of the patient group in the IPCU setting, the MDT were reviewing how the continued promotion of rights could be improved in the ward. We were pleased to hear and see that information on rights had being updated and consideration for options to make rights information more widely, for example the use of QR codes, was being taken into account to promote rights-based care for patients.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. One patient was specified on the day of the visit. Where specified person restrictions were in place under the Mental Health Act, we found comprehensive reasoned opinions and regular review of the restrictions in place.

The ward held regular community meetings called 'The Blackford Blether'. We were able to review minutes from recent meetings which were well attended by patients and co-ordinated by the activities co-ordinator. The meeting provided an opportunity for patients to give feedback on what was good in the ward and suggestions for improvement. During each meeting, patients decided on a mantra for the week such as the importance of respecting others. Patients we met with who attended the community meeting felt having a weekly mantra was important in creating a positive environment in the ward. The minutes of the meeting were sent to the SCN and RMO.

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found one advance statement in the patient files we reviewed. Some of the patients we spoke to were aware of advance statements however, had chosen not to complete

one. Other patients were unaware of advance statements. It was evident from review of patients' files and during discussion with some of the patients that they were not at a point in their recovery to be able to make decisions regarding their care and treatment.

We were told that advocacy was provided regularly in the ward by AdvoCard. We were told that advocacy attended the ward on request and provided a good service to patients who wished to engage with them. We were pleased that all of the patients we met with on the day of the visit either had in place, or had been offered advocacy support.

We made contact with AdvoCard following the visit. Staff from AdvoCard told us that they attended IPCU regularly and found ward staff supportive, adding that communication with the clinical team was positive. As previously raised in this report, AdvoCard told us that they were concerned that patients they worked with were not allocated an MHO following the granting of a STDC. We heard that the duty MHO will refer the patient to advocacy services however, it is common practice that an MHO is not designated until later on in the detention period requiring advocacy staff to offer additional support to patients to ensure they are aware of and being given the opportunity to exercise their rights. AdvoCard were of the view that in addition to their involvement, it is imperative for detained patients to have the safeguard of an MHO involvement to ensure awareness of rights and support to exercise rights.

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 and found evidence of a broad range of activities that were available for patients in Blackford Ward. The activity and occupation in the ward was mainly provided by the activities co-ordinator however nursing staff, the art therapist and volunteers were also involved. The patients we met with spoke very positively, and were complimentary, about the activities co-ordinator and the activities and occupation offered in the ward. Some patients told us that there were times of the week when there were less structured activities and they would prefer it if activities were offered throughout the week and weekend. We were pleased to hear that a second activity co-ordinator has been employed and will start work in Blackford Ward imminently, working at opposite times to the current activity co-ordinator, to ensure that opportunities to engage in structured activities is increased.

There was an activities board situated in the corridor of the ward that displayed the weekly timetable of what was on offer. The activities available included art therapy, therapet session, music group, arts and crafts, creative sessions, pool tournament, spa session, fitness club, quizzes, movie nights, and gardening group. We heard that some patients attended the Hive day service, an activity centre situated in the grounds of the hospital.

We met with the art therapist who told us that there was a weekly art therapy group. The group supported patients to work creatively to develop alternatives ways of expressing emotions, relating to others, communicating, and problem solving. In addition to group work, art therapy

was available on a one-to-one basis for patients where it has been assessed by the MDT that they would benefit from this therapeutic intervention.

We heard, and saw, volunteer involvement in the ward. On the day of the visit, a volunteer was playing music to the patients which was very well received by those who attended. We made contact with the Volunteering Hub prior to the visit and were told that the support of the activity co-ordinator made it possible for a range of volunteers to attend an IPCU setting and for them to feel confident to work with patients who were acutely unwell.

On review of the care records, we did not find any recording of activities. Instead, we found recording of the activities in the activities care plan. The activity care plans we reviewed evidenced good quality recording, which was person-centred, strengths-based, and provided detail on each patient's experience when engaging in the activity. However, we would prefer to have seen information on activities recorded in care records so that it is easily located and recorded alongside the rest of the MDT's information on patient care planning. We discussed this with the SCN on the day of the visit who agreed, adding that there was a plan for activity co-ordinators to record activity and occupation in the care records.

The physical environment

Blackford Ward is a mixed-sex IPCU, therefore the physical environment had to be managed to support patients to feel safe and comfortable in the ward setting. The bedroom space in the ward was divided into a male and female area. Each bedroom had en-suite facilities and we heard, and saw, that patients could personalise their room if they choose to.

The cleanliness of the ward was of a high standard. The ward had a range of spaces available for patients to use, such as male and female lounges, and a dining area that had soft furnishings and art work, which created a comfortable environment for patients. There was an activity and games room in the ward that had facilities such as a play station, TV, table tennis and gym equipment for patients to use. We heard from staff and patients that the games room tended not to be used by patients. Patients we met with on the day of visit told us that they had provided feedback to staff on how the games room could be developed to promote better patient use of the room. The SCN told us that a review of this space was in progress and patient views would be considered during the review.

There was a courtyard garden area that was easy for patients to access. Patients could access the garden area throughout the day and until late evening. We heard that there was a weekly gardening group that took place in the courtyard. The garden group members and staff had worked alongside volunteers, which, along with the arts and garden health programme, had helped to refurbish the garden area. We were impressed with the planters that had flowers, herbs and vegetable planted by patients. As well as providing therapeutic benefits to the patients who engaged in the gardening group, the refurbishment of the courtyard provided a pleasant and relaxing space for patients to enjoy.

We made a recommendation in the previous report that an action plan should be developed to provide a smoke-free environment. We were told and saw that the ward was now a smoke-free. The SCN told us that patients who smoke had been offered supports such as nicotine replacement therapy. Some of the patients we met with told us that they would prefer the

option to smoke in the courtyard and found it challenging not being able to smoke. Some of the patients we met with told us that they did not find nicotine replacements helpful however accepted that the ward was a smoke-free environment. The SCN told us that the clinical team regularly reviewed the patients who smoked and found an escalation of agitation around previous 'smoke times'. There was an arrangement with the clinical team that staff would continue to provide additional support to patients who required it at the identified times and also out with these when necessary.

Any other comments

We heard that there were some staff shortages in the ward, mainly band 3 vacancies; there was some use of bank staff however, bank staff were not used regularly thereby promoting consistency of patient care. All the staff we spoke to told us that they were happy working in the ward, adding that the staff morale was good. We were encouraged to hear that some nursing staff had been supported to develop their skills and complete a nursing qualification. We heard from some newly qualified staff that they had had additional support from a preceptor in the first year, post qualification, which was positive. All staff spoken to told us that they benefitted from regular supervision and attended reflective practice sessions. Some staff felt that more regular team meetings would be beneficial; we fed this information back to the SCN.

We heard and saw evidence of good leadership in Blackford Ward. The ward has had a consistent SCN and RMO for a prolonged period of time which had been positive in terms of consistency of care and support to patients. Every staff member we spoke to told us that they felt supported by the SCN. We were pleased to see the positive working culture the SCN had promoted in the ward setting. It was evident that with the ethos of the ward, there was a commitment to provide high standards of care to patients and support staff to enable them to provide high quality patient care.

Summary of recommendations

Recommendation 1:
Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the care needs of each person and identify clear interventions and care goals.

Recommendation 2:
Managers should review the occupational therapy provision in Blackford Ward to ensure greater equity of occupational therapy provision across the Royal Edinburgh Hospital services.

Recommendation 3:
Managers should urgently ensure a pathway is developed in partnership with social work colleagues to support timely allocation of an MHO for detained patients.

Service response to recommendations

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

A copy of this report will be sent for information to Healthcare Improvement Scotland and City of Edinburgh Council senior social work managers.

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.

Contact details

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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk