Mental Welfare Commission for Scotland

Report on an announced visit to: Balcarres Ward, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH20 5HF

Date of visit: 29 April 2024

Where we visited

Balcarres Ward is a 16-bedded adult acute mental health assessment, care and treatment ward for adult males. Balcarres Ward covers the catchment area that includes the northwest and east areas of NHS Lothian. On the day of the visit, the bed capacity had been increased to 17 beds with the use of a contingency bed located in the quiet room.

We last visited this service in March 2023 on an unannounced visit and made recommendations on ensuring care records were completed by the multi-disciplinary team (MDT), that care plans were person-centred, and reviews should be meaningful and reflect any changes in the individuals' care needs and that rights-based care was delivered to individuals. We also recommended that managers should urgently review the psychology provision in the ward, that consent and authority to treat certificates were valid and record a clear plan of treatment, that outstanding environmental factors were addressed, and the dedicated quiet room should be returned to a therapeutic and quiet space for individuals to use.

The response we received from the service included plans to provide care plan training, regular audits of care plans and reviews that were to be completed. All authority to treat certificates were to be reviewed and monitored at the weekly MDT meeting, staff would promote discussion regarding rights with individuals and consider the use of QR codes to provide additional information on rights and recruitment for psychology was to be progressed. The service response also included plans to monitor the cleanliness of the ward and "when not required as a contingency bedspace, the bed will be removed from the quiet space and patients encouraged to use this space".

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

We met with seven people and reviewed seven sets of care records. No relative/carers requested to meet with us.

We spoke with deputy charge nurse, the clinical nurse manager (CNM) the senior charge nurse (SCN), other ward-based nursing staff and the recreational nurse.

Commission visitors

Kathleen Liddell, social work officer

Alyson Paterson, social work officer

Gillian Gibson, nursing officer

What people told us and what we found

Comments from individuals

The individuals we met on the day of the visit provided mixed feedback about their care and treatment in Balcarres Ward. We heard from most individuals that they were able to identify a member of the team that they felt able to engage with. Some of the individuals told us that many of the staff were "kind" and that the "ward was great". Individuals told us that they saw medical staff regularly and found this "helpful" and "positive". Unfortunately, there was also negative feedback given to us. Individuals told us that the ward was short staffed and the impact of this was that they were able to leave the ward when on escorted pass. A number of individuals told us that some staff "lacked empathy", "spent more time in the office than with patients" and that there could be "an uncomfortable atmosphere" in the ward depending on which staff were on shift. Individuals who spoke with us highlighted that at times, there was a negative atmosphere on the ward, due to challenges and friction within the staff group. We heard and observed the impact of some nursing practices and the culture issues that affected individuals in Balcarres Ward.

We discussed these concerning comments with the senior management team who advised us that they were aware of the team dynamics and the impact that this had on patients' care. The managers agreed that work on team building was required as a priority, to ensure that the care of the individuals on the ward was not affected further by the current team challenges. When we asked if there were other plans in place to address these matters, we were told by the CNM and deputy chief nurse that strategies to manage this would be discussed with the senior management team.

None of the individuals that we spoke with were aware of their care plan; most had no awareness of this, had not participated in it and did not feel involved in discussions or decisions regarding their care plan.

We heard from most that they felt "bored" and there was not much planned activity on the ward. We did hear about a positive change with the recent addition of the recreational nurse to the MDT, and many of the men we spoke with agreed, and spoke highly of the recreational nurse input.

Many individuals reported that they had either witnessed or been involved in "fights" with others on the ward. We heard the fights were mainly in relation to issues around cigarettes and/or the TV. Some individuals told us they did not always feel safe in the ward and tended to spend time in their room when there was increased tension in the communal area.

Comments from staff

We heard that since our previous visit, the senior change nurse (SCN) and one charge nurse had left post, and the ward had been without a SCN for a period of 6 weeks until the new SCN came into post in January 2024. We heard from staff that the lack of management support during this period, along with inconsistent responsible medical officer (RMO) cover and three significant incidents in the ward involving the death of individuals, had had a negative impacted on staff morale and attitudes. We heard that there was some friction in the team and the focus of SCN's time was spent working on individual staffing issues, with a recognition

that team building was required. We heard from some staff on the ward that it could be difficult to suggest new ideas to the staff team as they could be unwilling to consider change which could cause “frustration” and at times “tension”.

On a more positive note, all of the staff that we spoke with told us that they enjoyed their job, were committed to providing good care to the men they worked with and felt mainly supported by their colleagues. All staff were aware of “team issues” however did not feel it impacted on their ability to undertake their role.

Some of the newer qualified staff said they would benefit from additional input from the ward management team to support them in their role. We raised with the senior management team the importance of the newly qualified receiving regular support and were advised that contact would be made with Royal Edinburgh Hospital (REH) nursing educators who had a role in supporting newly qualified staff.

Care, treatment, support and participation

Nursing care plans

Nursing care plans are a tool, which 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 that were stored electronically on TRAKCare. We found that mainly, the care plans in Balcarres Ward were poor quality. We made a recommendation in the previous visit report that care plans should be person-centred, contain individualised information, reflect the care needs of each person and identify clear interventions and care goals. We were disappointed to see that little progress had been made in improving the quality of care plans. The care plans we reviewed lacked person-centred detail and did not evidence strengths based, goal or outcomes focussed interventions. We did not see involvement from the individual in their care plan which was confirmed during discussions with individuals who were unaware they had a care plan.

We were told that a comprehensive assessment was completed on admission to Balcarres Ward, and that this supported the gathering of person-centred information on the individual’s personal circumstances to ensure a holistic approach to their care and treatment. From the care records were reviewed, we saw one comprehensive assessment had been completed. The information in the assessment reviewed was not person-centred and did not evidence participation from the individual. This was disappointing, as we believe that a comprehensive assessment could lend itself to promoting person-centred and individualised care, if the appropriate information was recorded alongside the participation of the individual. We discussed with the deputy chief nurse, CNM and SCN that completion of the comprehensive assessment was an opportunity to promote the participation of the individual and gather information that supported person-centred and individualised care.

We heard from some individuals and saw from review of care records that they did not attend MDT meetings, therefore were not involved in any discussions regarding their care and treatment. We saw that the RMO met the individual regularly and did discuss their care plan however, the discussions that were recorded did not always align with the content of the MDT

meeting. We did not see individuals being given an opportunity to provide their views/wishes to the MDT from either a discussion with staff or attendance at the MDT meeting. We heard that individuals were able to attend the MDT meeting if they wished however, individuals were unaware of this and the arrangement was unclear. Individuals told us that they would have liked to be more involved in decisions regarding their care. We discussed with the CNM and SCN that the arrangements for attendance at the MDT meeting should be confirmed and communicated to individuals to allow them to make an informed decision as to whether they wished to attend and participate in the meeting.

We heard that the RMOs met with the community mental health teams (CMHT) weekly to discuss discharge planning. We heard that the meeting discusses appropriate supports available for the individual from either CMHT or intensive home treatment team (IHTT). We saw some evidence of good working relationships across the inpatient and community teams with some positive examples of discharge planning. Many of the individuals spoken to were unaware of discharge planning however, on review of the care records we saw that discharge planning was in progress and included evidence of comprehensive discharge planning that involved the MDT and community services including social work, CMHT, and IHTT. We discussed with the CNM and SCN that consistent communication and discussion with individuals is required to ensure they are aware of discharge planning.

We found that several of the individuals in Balcarres Ward were delayed in their discharge from the ward. We heard that the delays in discharging patients was in relation to a lack of community services and capacity issues in other parts of the service, mainly the rehabilitation services.

We made a recommendation in the previous report in relation to care plan reviews that they should be meaningful, include effectiveness of interventions and reflect any changes in the individuals care needs. When we reviewed the care plans, we were unable to locate robust reviews which targeted nursing intervention and individuals' progress. We discussed this with the SCN and CNM on the day of the visit who acknowledged that improvements to care planning and reviews was required. We were encouraged to hear that a project was underway to develop a new care plan that will be specific to individuals admitted to a mental health ward. We were told that the new care plan was expected to be available on the electronic record system, TrakCare in summer 2024.

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 there is a system in place for all individuals that is understood and offers them an opportunity to engage in meaningful participation in care planning and decisions about their care and treatment. The participation of the individual should be recorded in their clinical notes.

Recommendation 2:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out and any changes required to meet care goals.

Care records

Information on individuals' care and treatment was held electronically on TrakCare. We found this easy to navigate.

We made a recommendation in the previous report that the quality of the care records was mixed and that not all members of the MDT recorded in the care records, specifically in relation to activities and occupation. We were concerned to find a further deterioration in most of the care records reviewed. We were disappointed in the use of some language recorded in the care records. We found that language such as "evident on the ward" and "keeping a low profile" was used regularly in Balcarres Ward. We do not consider that this language provides good quality detail on the individual's current circumstances, mental state, or interventions provided by staff and would prefer care records contained person-centred and personalised information. We were also concerned about the use of pejorative, critical, and judgemental language where staff referred to individuals as abrupt, brittle, rude, and misogynistic.

It was evident from reviewing the care records that there were high levels of clinical acuity, stress and distress, and at times verbal and physical aggression directed towards staff. While we appreciate this can be challenging for the MDT to manage, we would prefer that the MDT adopt a more empathetic, therapeutic and strengths-based approach to supporting individuals during times of stress and distress. We would expect care records to be professional and all entries by nursing staff to reflect the Nursing and Midwifery Code. We discussed this with the deputy chief nurse and CNM on the day of the visit who agreed that this use of language was not appropriate or professional and would take urgent action to address the Commission's concerns.

We were pleased to find comprehensive care recording from some members of the MDT. The records from the art psychotherapist, music therapist, occupational therapist (OT), junior doctors, physiotherapist, and physician associate were personalised, outcome and goal focussed, and included forward planning. We were encouraged to see regular and comprehensive reviews of individuals by their consultant psychiatrists.

As found with our visit last year, we did not find regular one-to-one interactions between individuals and staff. We heard that there had been an increase in these following the Commission visit in 2023; however, this was not evident in the care records reviewed.

We were pleased to find that the care records included regular communication with families and relevant professionals.

We found the majority of risk assessments to be comprehensive and of a good standard. Most of those that we reviewed clearly recorded risk, with a plan to manage each identified risk. We did however find some examples of risk assessments where the individual had been admitted for a prolonged period, and the risk assessment recorded vast amounts of information on

historical risks, which made it difficult to ascertain current risks and the associated risk management plan. We highlighted these risk assessments to the SCN, suggesting that these would benefit from having a summative evaluation to ensure current risk factors were clear. We found regular review of the risk assessments and evidence of changes following review when there was progress or a new/increased risk.

We saw that physical health care needs were being addressed and followed up appropriately by junior doctors and the physician associate. The medical reviews were of a high standard and included comprehensive information that was personalised and detailed forward planning for care and treatment. We saw some good examples of individuals participating in discussions with junior doctors regarding their physical health care and being involved in future planning.

Recommendation 3:
Managers should urgently review the care records and ensure that all members of the MDT involved in a person's care record their input in the individual's care records. All entries should be personalised, strengths-based, goal and outcome focussed, and provide detail of interactions between individuals and staff.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to medical and nursing staff, the MDT included a recreational nurse, a physician associate, and a pharmacist. We were pleased to find regular input from physiotherapy in the care records we reviewed.

We made a recommendation in the previous report that mangers should urgently review the level of psychology provision in Balcarres Ward. We were told on the day of the visit that there had been no consistent psychology provision in the ward since the previous visit. We heard that if an individual required psychology involvement, a referral could be made to the psychology service. We were pleased to hear that the psychology post had been filled and they would be in post by summer 2024. We heard that psychology provision in the ward will be 2.5 days a week.

On the day of the visit there was no input from the art psychotherapist or music therapist. We were told that both services had recently finished their involvement in Balcarres Ward, although we were pleased to hear that art psychotherapy will recommence in June 2024

We heard that there had been inconsistent RMO cover in the ward. There was one permanent consultant psychiatrist and a ST6 (speciality trainee doctor). We were pleased to hear that a new permanent consultant had been recruited and would start post in August 2024. Until this time, locum consultants will provide consultant cover.

The consultant psychiatrists dedicated to the ward held a weekly MDT meeting. In attendance at the meeting were medical staff, nursing staff, and pharmacy. We also saw that social work and CMHT were in attendance at some MDT meetings. During our previous visit, we heard that a new structured MDT meeting template was being trialled to improve the quality and consistency of information recorded at the MDT meeting. We were pleased with the quality of the MDT meetings records. The structured template was being used and had headings

relevant to the care and treatment of the individuals in Balcarres Ward. We found these records to be comprehensive and they contained detailed recordings of the MDT discussion and decisions, which promoted a holistic approach to individuals' care. We saw input from family members either in attendance or providing information and views to the MDT.

Use of mental health and incapacity legislation

On the day of our visit, 11 individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was stored electronically on TrakCare and easily located.

The individuals we met with during our visit had a mixed understanding of their detained status and their rights under the Mental Health Act. From the files we reviewed, there was evidence of legal representation and advocacy involvement to support individuals in understanding their legal status and how to exercise their rights.

Part 16 (sections 235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained individuals who are either capable or incapable of consenting to specific treatments. This includes the requirement for a second opinion from 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 if consent is not/cannot be obtained, or a T2 certificate if the individual is consenting.

We reviewed the prescribing for all individuals, as well as the authorisation of treatment for those subject to the Mental Health Act. We found a T2 with signed consent in place which covered several different psychotropic medications, including an antipsychotic which we heard and saw from care records the patient had been recently refusing. We were reassured to note that the RMO had requested this medication be covered by a T3. We spoke with the SCN about this on the day of our visit who told us this individual's capacity to consent fluctuated. We advised that capacity and consent should be assessed for each treatment offered.

We were concerned to note that IM "as required" psychotropic medication was included on a T2 form and prescribed however, had not been administered. We consider this practice inappropriate in most cases; this is because any advance consent the individual has given is invalid if they have withdrawn their consent at a later time when the medication is given or if restraint is involved. It is the Commission's view that IM medication prescribed in advance on an "as required" basis should be authorised on a T3 form. We raised this with the SCN who agreed to urgently discuss this with the RMO.

Medication was recorded on the hospital electronic prescribing and medication administration system (HEPMA). T2 and T3 certificates authorising treatment were stored separately on TrakCare. We have found on other 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 the correct legal authority is in place when prescribing or dispensing treatment for those who are detained. For this reason, we usually suggest 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. We were pleased to find a folder containing paper copies of all T2 and T3 certificates available on Balcarres Ward.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found this stored on TrakCare.

Rights and restrictions

Balcarres Ward continues to operate a locked door, commensurate with the level of risk identified with the patient group. The ward had a locked door policy that was displayed at the entrance door.

We made a recommendation after our previous visit in relation to rights-based care being delivered to individuals and information on rights being visible throughout the ward. We were pleased to see progress in rights information being displayed in the ward. We saw an information board at the entrance to the ward, which contained advice and guidance on rights, legal representation, and advocacy services. We were pleased to hear that the service had developed QR codes for information on rights for formal and informal patients which would be available to display imminently. Given that some of the individuals did not have a good understanding of their rights, we discussed with the SCN, the importance of staff having regular follow up discussions with individuals regarding rights to ensure rights-based care was being actively promoted. We discussed with CNM and SCN that in other areas of NHS Lothian there was a care record titled ‘rights read’ which promoted discussion regarding rights.

The CNM told us contact had been made with the quality improvement team and other services across NHS Lothian following another recent Commission visit to the REH, where a similar issue had been raised and a request had been made for the adult acute services to have access to the ‘rights read’ care record to promote regular discussion on rights.

We reviewed the care record of an individual who was informal and found that an agreed pass home had been “cancelled” following the individual being involved in “an incident” in the ward. It was clear from review of the care records that the individual was not in agreement with the decision to “cancel” the arranged pass. We reviewed the individuals’ pass plan and were concerned to see that the plan did not record the consent of the individual or comprehensive information regarding agreed pass plan arrangements. Any restrictions placed on an individual who is informal must record the individual’s view, give clear evidence of consent, and set out timescales for review of the restrictions. We raised with the deputy chief nurse, CNM, and SCN that when an individual who is informal does not consent to pass arrangements, it was unlawful and a deprivation of the individual’s liberty to impose this level of restriction on them.

We saw that each detained individual received a letter from medical records following detention under the Mental Health Act that included information on their detained status and their rights in relation to this. We were pleased to see the introduction of a letter sent to

relatives/carers when their family member is admitted to the ward. The letter included information about the ward and details of the doctor and nursing staff who would be supporting the individual.

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 an individual 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 individual was subject to specified person restrictions on the day of the visit. We found all documentation completed, recorded on TrakCare and regularly reviewed.

One individual was subject to continuous intervention on the day of the visit. We met with the individual and reviewed their care records. We found a care plan detailing the requirement for continuous intervention and were satisfied that the care plan goals and outcomes supported the individual in terms of identified risk. The continuous intervention care plan invited staff to engage and support interventions, such as therapeutic conversation with the individual.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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 did not see any copies of an advance statement. Some of the individuals we spoke to were aware of advance statements however, had chosen not to complete one. Others were unaware of advance statements. It was evident from review of the individual files and during discussion with some of the individuals that they were not at a point in their recovery to be able to make decisions regarding their future care and treatment. We discussed the responsibility of the health board in promoting advance statements with the CNM and the SCN and made suggestions, such as including advance statement discussion into the MDT meetings, as well as discharge planning discussions.

We were told that there was a weekly community meeting in Balcarres Ward. The meeting was an opportunity for individuals to communicate their views on any issues in the ward and discuss these with each other and staff.

We saw information displayed in the ward in relation to staff information, for example, who was on shift and names of each MDT member, the times of MDT meetings and times of meals. Individuals told us that they found this information helpful.

We were told that advocacy service, Advocard, was regularly involved with the service. We were told that advocacy attended the ward on request and provided a good service to individuals who wished to engage with them. We were pleased that all of the individuals we met with on the day of the visit either had or had been offered advocacy support. In addition to advocacy input, we saw for one individual that they had met with members of the REH patient council to discuss an application for a welfare guardianship order and their rights in relation to this.

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

Recommendation 4:
Managers and medical staff must ensure that any restrictive practices are lawful, proportionate, evidenced, understood, discussed with patients, and are the least restrictive option.

Activity and occupation

We heard from the SCN that the recreational nurse who provided the activity in Balcarres Ward had left post shortly after the last visit and that the ward had been left without a dedicated recreational nurse for some time. We saw from our review of the care plans and care records that there were no activity care plans and a lack of activity recorded in care records.

We were pleased to see that a new recreational nurse had started post in March 2024. We heard from individuals and saw in care records that there was a lack of planned activity in the ward. We saw and heard that there were some opportunities for individuals to engage in activities such as a weekly coffee morning organised by the OT, playing pool, individuals attending the activity room where arts and music activities were available. However, we heard and saw that planned activity was not regular. This resulted in individuals reporting feeling "bored" and having long periods during the day where no activity was planned.

The information board in the ward provided information on activities that took place at the HIVE. The HIVE is a day service run by SAMH, situated in the grounds of the Royal Edinburgh Hospital and offers a variety of activities and groups. Individuals can attend the HIVE, although this is dependent on risk assessment and pass time off the ward.

We heard that the ward has a volunteer who attends regularly with a therapet. We met with the volunteer and the therapet dog on the day of the visit and saw positive interactions between individuals, the volunteer, and the therapet dog.

We met with the recreational nurse to discuss the plans for activity in Balcarres Ward. We heard that the focus at present was taking time to meet with the individuals and create a person-centred and individualised care plan. We asked about the plan to arrange regular planned activity in the ward, as we would expect individuals in Balcarres Ward to have access to regular activities to maximise therapeutic benefits, improve mental well-being, increase social interactions, and reduce stress and distress. We were told that feedback from the individuals would inform what planned activities would be arranged.

We discussed with the SCN that we did not see any record of activity care plans or activity recorded in the care records. We heard that ongoing training was being offered to staff to ensure that activity was being regularly recorded.

Recommendation 5:
Managers should ensure that there are structured activities regularly available to individuals that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

The physical environment

We raised concerns in our previous report and made a recommendation about the outstanding environmental issues in relation to decoration, cleanliness, and maintenance. We were pleased to see significant improvement to the cleanliness of the ward. We were disappointed that the ward had not been decorated since the last visit however, we were told that the ward is on a list to be painted.

The lounge and dining area were situated at the entrance of the ward and had some artwork which promoted a more homely environment. Individuals tended to spend a lot of time in the communal areas and we observed it was busy on the day of this visit, with individuals using the areas to watch TV and have a hot drink. The individuals were able to use the kitchen facilities which were attached to the communal area to make a hot drink and snack and had access to the outside courtyard until midnight. Occasionally during the visit, there was increased noise levels in these areas, and it was easy to understand why some individuals found the communal area intimidating.

We were able to see some of the individuals' bedrooms. The bedrooms viewed had en-suite facilities and were personalised. Some bedrooms we viewed were untidy and cluttered. In contrast, other rooms were very clean and tidy. We heard that for individuals who needed support in relation to their keeping their bedspace clean and tidy, they were given additional input from the housekeeper and domestic staff. We raised with the CNM and SCN that for individuals who needed support in this area, we would expect there to be a care plan for the individual, setting out how they would maintain a standard of cleanliness in their bedroom space.

We raised in our previous report that there was a contingency bed in the quiet room on the day of that visit, although it was not being used. We heard that the quiet room was generally now used as a bedroom and we found that on the day of the visit, the quiet room had a surplus bed in it. This room does not have washing or toilet facilities, compromising the individual's right to privacy and dignity. Although we recognise that there is a shortage of beds, we do not consider using the quiet room to be appropriate or safe as an individual's bedroom. Given the increased levels of acuity, Balcarres Ward would benefit from having a dedicated quiet space for individuals to have access to during periods of stress and distress and to support de-escalation.

We also raised in our previous report that individuals continued to smoke in the courtyard and found this still to be the case. We were told that NHS Lothian were reviewing all smoking policies in order to support the implementation of the Scottish Government law passed in September 2022 which prohibited smoking in hospital building and grounds. We also heard that senior managers had been consulting with other health boards to gather information and advice on supporting the implementation of the smoking law.

On the day of the visit, we saw evidence of individuals smoking in the courtyard and heard that some individuals regularly smoked in the ward. We saw some signage on the doors leading to the courtyard asking individuals to refrain from smoking however, we also saw bins in the courtyard used to dispense of cigarettes. Individuals and staff that we spoke with reported that it had been difficult to support the implementation of the current legislation. We are aware

of the challenges for individuals not being able to smoke, which for many was against their views and wishes. We also heard from individuals who did not smoke and the negative impact smoking in the courtyard had on them. We discussed with the CNM that more proactive approaches to support the implementation of the non-smoking law, such as non-smoking signage in the ward, nicotine replacement therapy, and smoking cessation support should be available. Individuals and staff require clear guidance and support from senior NHS Lothian managers to support implementation of the current legislation and a reminder that is against the law for smoking to take place within 15 metres from a hospital building. The CNM told us that a decision had been taken by the senior management team that from 17 June 2024, the REH would operate as smoke free. We were told that support from smoking cessation was being increased and in addition, consent forms will be provided to individuals on admission to remove tobacco and lighters to support the initiative.

Recommendation 6:
Managers should consider returning the dedicated quiet room in the ward for the purpose of therapeutic and quiet space for individuals and staff.

Recommendation 7:
Managers should ensure the NHS Lothian's 'no smoking policy' is explained to and complied with by all individuals in the ward, and that staff are given support to manage this.

Any other comments

We recognise that individual feedback was generally not positive, and we are aware of the negative impact this may have on the staff team who already felt the challenges and pressures of working in a busy acute setting. The nursing staff we spoke with were committed and motivated to providing good quality care to individuals. The SCN had only been in post for three months at the time of this visit and given the issues raised in the report, will need significant support from the REH senior management team to work on and resolve the team issues. Many of the recommendations made in this report are similar to the recommendations in the previous report. The lack of improvement made and, in some areas, further deterioration since the visit in 20 March 2023 is a concern. There is therefore a need for senior managers to develop a contingency plan that will enable all members of the MDT and new staff, to feel supported to ensure that person-centred care is delivered to individuals in Balcarres Ward.

We appreciate the competing demands staff have to manage, nevertheless, it is vital that the care and treatment needs of the individual remain paramount, with staff delivering care that is professional and supports a therapeutic and trusting relationship with the individual. We would expect the standard of nursing care provided to individuals to align with what is expected in the NMC Code of Practice.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is a system in place for all individuals that is understood and offers them an opportunity to engage in meaningful participation in care planning and decisions about their care and treatment. The participation of the individual should be recorded in their clinical notes.

Recommendation 2:
Managers must ensure nursing care plans are person-centred, contain individualised information reflecting the care needs of each person, identify clear interventions and care goals, include a summative evaluation indicating the effectiveness the interventions being carried out, and any changes required to meet care goals.

Recommendation 3:
Managers should urgently review the care records and ensure that all members of the MDT involved in a person's care record their input in individuals' care records. All entries should be personalised, strengths-based, goal and outcome focussed, and provide detail of interactions between individuals and staff.

Recommendation 4:
Managers and medical staff must ensure that any restrictive practices are lawful, proportionate, evidenced, understood, discussed with patients, and are the least restrictive option.

Recommendation 5:
Managers should ensure that there are structured activities regularly available to individuals that have a therapeutic and well-being focus. Managers should ensure that activity participation is recorded and evaluated.

Recommendation 6:
Managers should consider returning the dedicated quiet room in the ward for the purpose of therapeutic and quiet space for individuals and staff.

Recommendation 7:
Managers should ensure the NHS Lothian's 'no smoking policy' is explained to and complied with by all individuals in the ward, and that staff are given support to manage this.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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