**Mental Welfare Commission for Scotland**

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

**Date of visit:** 15 April 2024

## Where we visited

Meadows Ward is a 16-bedded adult acute admission ward for females, with a catchment area for the southwest and southeast areas of Edinburgh. On the day of the visit, the bed capacity had been increased to 17 beds with the use of one contingency bed located in the quiet room. We were told that some individuals who met the criteria for the ward were boarding in other female acute wards across the hospital site due to no bed capacity in Meadows Ward.

We last visited this service in September 2022 and made recommendations on ensuring meaningful participation in care and treatment was supported for individuals and their relative/carer. The care records and nursing care plans were to be more person-centred and individualised, and they should have identified, clear interventions and care goals. There was to be a consistency of multi-disciplinary team (MDT) meetings, as well as recording of decisions for every individual and any restrictive practices were to be proportionate, the least restrictive option, and that these restrictions were to be understood by and discussed with the individual. The response we received from the service included plans to improve staff training on care planning, improve quantity and quality of one-to-one interventions, introduce a structured MDT meeting template on TRAKCare, and for staff to attend training in relation to rights-based practice.

We were advised that a new project to develop a person-centred care plan was underway across the Royal Edinburgh Hospital site. We heard that the acute service was trialling the new care plan and feedback on the views of the new care plan template to the project team would take place before it was implemented for all individuals.

On the day of this visit, we wanted to follow up on the previous recommendations, in particular to find out if there had been progress made towards increased involvement of the individual in decisions regarding their care planning. We also wanted to meet with individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on Meadows Ward.

## Who we met with

We met with eight people and reviewed eight sets of care records. We also met with one relative/carer.

We spoke with deputy charge nurse, the clinical nurse manager (CNM), senior charge nurse (SCN), charge nurses, nursing staff, psychologist, and student nurse. In addition, we made contact with the art therapist following the visit.

## Commission visitors

Kathleen Liddell, social work officer

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

## What people told us and what we found

The individuals we met on the day of the visit provided mixed feedback about their care and treatment in Meadows Ward. We heard from most individuals that staff were generally "supportive and caring", "staff make an effort to spend time to get to know me and offer regular one-to-one support". We heard from one individual that when they were "going through a hard time'" they received a hand-made picture made by a staff member and it really cheered them up. We heard from another individual that staff had "supported me to build up my confidence to go home" and that the admission had been "very beneficial". We heard from most individuals that they had good support from the full MDT and in particular, they found interventions from occupational therapy (OT), music therapy, and physiotherapy to be "positive and supportive". We heard from individuals that they saw their consultant psychiatrist regularly in the ward.

Individuals also told us that the ward was regularly short staffed. We heard that on these occasions staff could present as "stressed and less considerate", which caused individuals to feel they were "causing a problem". We heard from a number of individuals who had previously been admitted to Meadows Ward, that the ward environment had changed and there were higher levels of acuity and aggression directed towards staff and other individuals. Individuals told us that the ward environment was "not therapeutic" and there were times they did not feel safe.

Very few of the individuals we met had been involved in their care plan; some were unaware they had one. Most individuals reported that they did not feel involved in discussions and decisions about their care. This was a concern, as promoting participation was a recommendation in our last report. We heard from staff and saw in our review of the care records that there was an inconsistency in individuals attending MDT meetings. However, we did see regular meetings between individuals, nursing staff, and consultant psychiatrists, where there were discussions about care and treatment. Nevertheless, the feedback from individuals continued to be that meaningful participation was not promoted. We were disappointed to hear that there had been limited progress in promoting participation. The practice we heard about in Meadows Ward did not align with the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) principle of participation which encourages and allows individuals to be involved in decisions about their care. We raised this with the deputy chief nurse and CNM on the day of the visit.

### Comments from family

We met with one relative/carer. We heard that in general they were happy with the care provided to their relative. We heard that communication with staff and doctors was satisfactory although, mainly had to be initiated by the relative/carer. We heard again that the ward was short staff regularly and it was evident that staff were stressed. At these times, the relative/carer reported that some unhelpful comments had been made to them about their relative, by a member of bank staff, such as, "she is putting it on", which had understandably upset the family. The relative/carer told us that there was information on carers support in the ward and that they had made contact with the service. We discussed the comments from the relative/carer with the senior management team on the day of the visit.

### Comments from staff

We heard from staff that we spoke with that the levels of acuity in Meadows Ward had significantly increased over the past year. We heard that there had been frequent and more serious incidents of self-harm on the ward, as well as increased levels of physical aggression directed towards staff. Staff reported that they found these issues difficult to manage and challenging to deal with however, they remained committed to providing high quality care and support to individuals. All staff we spoke with felt supported by the ward management team. We heard that psychology offered good input to staff to support them in their role of managing increased acuity and physical aggression. Staff told us that they found this support very positive.

We spoke with a student nurse and staff member who was completing an NHS modern apprenticeship placement. Both had found their time in Meadows Ward positive, reporting that the team had been supportive. We heard from the student nurse that once registered, they would consider working in Meadows Ward, as their experience of working in the ward had been positive.

There were four band 5 staff nurse vacancies at the time of the visit. Staff told us that it was unusual to have the full complement of staff on shift and the ward management team regularly had to be part of the nursing numbers. We observed the ward being short staffed on the day of the visit; this was due to sickness. We heard that there was regular bank staff who covered the staff shortages.

**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.

## 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 in order to provide a record of progress being made.

We reviewed the care plans that were stored electronically on TRAKCare. We had made a recommendation in our previous visit report that care plans should be person-centred, contain personalised information, reflect the care needs of the individual, and identify clear interventions and care goals. We found that there had been some improvement in the quality of the care plans in Meadows Ward. However, were disappointed to see the progress was limited and inconsistent. Some of the care plans we reviewed lacked person-centred detail, and did not evidence strengths based, goal or outcome focussed interventions. In contrast, some care plans that we reviewed recorded comprehensive, person-centred, and strengths-based information in relation to care goals and how the intervention would be provided by staff.

We did not see consistent involvement from the individual in their care plan. When participation from the individual was evident, we found the care plan to be more person-centred, individualised and strengths based.

We found that a comprehensive assessment was completed at the time of admission to Meadows Ward. We were told that this template supported the gathering of person-centred information on the individual's personal circumstances; this was to ensure a holistic approach to their care and treatment. The majority of the assessments we reviewed had been recently completed, even although the individual had been admitted for a period of time. The majority of the information in the assessments 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 relevant information was recorded alongside the participation of the individual. We reviewed one assessment that recorded good quality information on the individual's circumstances. This information was reflected in their care plan and a more holistic and individualised approach to care was evident. We discussed with the deputy chief nurse and CNM that completion of the comprehensive assessment was an opportunity to promote the participation of the individual and gather information that supports person-centred and individualised care.

Most of the individuals we met with were unaware of discharge planning. One individual told us that they had a discharge date and that they had been fully involved in discharge discussions and decisions. We reviewed the individuals care records and were pleased to find evidence of comprehensive discharge planning that involved the individual, the MDT, and community services.

When we reviewed the care plans, we found regular evaluations had been taking place. We were disappointed to find that the majority of the reviews were not comprehensive and did not evidence targeted nursing intervention and individuals' progress. We did find some examples of more robust reviews that indicated a change in support needs, which were subsequently reflected in the care plan. We discussed this with deputy chief nurse and CNM on the day of the visit; they 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. In addition, we heard that NHS Lothian had recruited three new development officers across the hospital site. One of whom will have a specific focus on improving the quality of care plans.

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 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 were pleased to see an increase in one-to-one interactions between individuals and staff. The recording of these interactions was comprehensive, and person-centred. We heard from individuals that they found one-to-one interventions with staff positive and beneficial to their recovery.

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 found regular reviews of the risk assessments, and evidence of changes made to the risk assessment following a review of the individual's progress or new/increased risk.

We saw that physical health care needs were being addressed and followed up appropriately by junior doctors and the advance nurse practitioner (ANP), where appropriate. The medical reviews completed by the junior doctors and ANP were of a high standard and included comprehensive information that was personalised; it also detailed forward planning for care and treatment. We were pleased to see comprehensive care recordings from most members of the multidisciplinary team (MDT). The care records of the music therapist, OT, physiotherapist, ANP, and dietician 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.

We were pleased to find an increase in the recording of communication with families and relevant professionals in the care records.

We made a recommendation in our previous report in relation to care records as we did not find them person-centred and there was a lack of interaction recorded between individuals and staff. We were told by the SCN that a template to record one-to-one interactions had been developed since the last visit. We were pleased to see some improvement in the quality of the information held in the care records. The continuation notes were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Meadows Ward. Most of the information recorded was detailed, personalised, and contained comprehensive information on the nursing intervention individuals required throughout the day. Some of the information recorded in care records was strengths-based and recorded discussions with individuals that explored their feelings and views. We were however disappointed in the use of some language recorded in the care records. We found language such as "evident on the ward" and "keeping a low profile" was used. We do not find this language helpful in providing the detail of the individual's current circumstances or of the interventions provided by staff and would prefer care records to contain person-centred and personalised information. On review of the care records in Meadows Ward, we found some

pejorative, critical, and judgemental language used, for example, referring to an individual as "rude and arrogant". It was evident from reviewing the care records that there were high levels of acuity, stress and distress in Meadows Ward. While we appreciate this can be challenging for the MDT to manage, we would prefer that the MDT adopt a more therapeutic and strengths-based approach to supporting individuals during times of stress and distress. We would expect care records to be professional and 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 and would discuss any training needs with the staff team alongside regular audit of the care records.

**Recommendation 3:**
Managers should 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 in the ward or accessible to the team. The MDT was made up of three consultant psychiatrists (two were in locum posts), a specialty doctor, junior doctor, nursing staff, psychology, and an art therapist. It was positive to note that there was regular input, discussion, and liaison from an advanced nurse practitioner, to support assessment and review of physical health care needs. Input from physiotherapy, speech and language therapy, and the dietician was evident in the care records. We were pleased to see regular mental health officer (MHO) involvement in MDT discussions. We saw that for some individuals, the MHO and consultant psychiatrist had met jointly with the individual to discuss the care plan, legal status, and their rights.

We highlighted in the previous report that there was no occupational therapy (OT) involvement with the individuals in Meadows Ward. We were therefore pleased to find a significant increase in this. We saw that for many individuals, OTs had completed functional assessments and were engaging regularly with individuals supporting the assessment outcomes. We saw that OTs were actively supporting discharge in providing some group-based activities out with the ward environment that many of the individuals in Meadows Ward attended and enjoyed.

During our last visit, a pilot social work (community care assistant) post was being trialled to support discharge and promote links with community based and welfare resources, such as the Department of Work and Pensions. We heard from individuals during that visit that the regular social work input was beneficial. We were disappointed to hear that the pilot post was not extended. The inclusion of social work in the MDT would further promote a holistic and full MDT participation in individuals' care. However, we did see that ongoing efforts were being made to support individuals with welfare issues. We met with one individual who had been supported to meet with a welfare rights officer to discuss benefit and housing issues and had found this input beneficial.

We met with psychology and heard that this support is available 2.5 days a week. We heard that the psychology input had increasingly been used to support staff due to the increased acuity and incidents of self-harm and aggression, to offer reflective practice sessions and also

to offer support for staff who had been involved in violent incidents. We heard and saw that psychology had completed formulations for some individuals and engaged in one-to-one interactions. We have raised in our previous report that increased psychology support would assist regular completion of psychological formulations of individuals and development of group work. We heard from staff that assistant and/or trainee psychology staff would be beneficial in assisting the development of psychological services. We were encouraged to hear that the service had recently employed a further full and part-time psychologist that will work in the acute wards across the hospital site.

Each consultant psychiatrist dedicated to the ward held weekly MDT meetings. In attendance at these meetings were medical staff, nursing staff, and at times, art therapy and psychology. On review of the MDT meeting paperwork, we found that attendance and involvement of the individual was inconsistently recorded. For some individuals, they were invited to attend their MDT meeting however, for others they were not. For these individuals, we saw that the consultant psychiatrist met with the individual following the MDT meeting to discuss the outcome of the meeting and decisions made. We heard from some individuals that although they found the meeting with the consultant psychiatrist beneficial, they did not feel that their views were fully considered during the discussion where decisions about their care was made. One individual told us they felt "out the loop" as they did not attend any MDT meetings in the ward.

We did not see consistent evidence of relatives/carers attending these meetings however, we did see communication with relatives/carers and their views were discussed as part of the meeting.

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

We made a recommendation following the previous visit in relation to full MDT discussions and decisions being recorded consistently. We were pleased to find significant improvement in the recording of these meetings. MDT meetings that we reviewed were recorded on a mental health structured MDT meeting template and held on TrakCare. The template had headings relevant to the care and treatment of the individuals in Meadows Ward. We found that these records were comprehensive and contained detailed recordings of the MDT discussion and decisions, which promoted a holistic approach to the individual's care.

## Use of mental health and incapacity legislation

On the day of our visit, 12 individuals in the ward were detained under the Mental Health Act. All documentation relating to the Mental Health Act and the Adults with Incapacity (Scotland) Act (2000) (AWI Act) were electronically stored on TrakCare and easily located.

The individuals we met with during our visit had a good understanding of their detained status under the Mental Health Act and of their rights regarding this. We were pleased to note from

the files we reviewed that there was evidence of legal representation and advocacy involvement to support individuals understand their legal status and 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 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 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 four individuals who had medication prescribed that was not authorised by the T3 certificates. We highlighted this issue on the day of the visit and were assured by the CNM that an urgent review of the T3 certificates would be undertaken.

**Recommendation 4:**
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised.

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 previously advised 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 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.

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.

There was one individual who had a welfare guardianship order granted in accordance with the AWI Act. We found details of the welfare guardian recorded, as well as regular communication to discuss the individual's care and treatment.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the 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. From the files we reviewed, we found that a section 47 certificate and treatment that had been completed and stored on TrakCare.

## Rights and restrictions

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

We made a recommendation after our last visit in relation to any restrictive practices being proportionate, evidenced, discussed and understood by individual. This was mainly in relation to informal patients who had restrictions on their pass plan that they had not consented to. We were told by the SCN that following this recommendation being made, the ward introduced a new pass plan that included a section specifically for informal patients to detail any restrictions on passes, the reasons for these restrictions, and the individual's consent. On review of the care files of individuals admitted to the ward on an informal basis, we were pleased to find that the pass plans had been completed and consent provided. We noted in some pass plans that where there were restrictions in place and that although consent was recorded, we would prefer the reasons for the restriction to be more detailed, including the individual's view and timescales for review of the restrictions.

We were pleased to hear that since the last visit, the service had developed information to promote rights-based care. The SCN told us that there had been contact with another NHS health board to discuss how they promoted rights in acute ward settings. We were pleased to hear that the service had developed QR codes for individuals that provided information on medication. We heard that QR codes were also being developed for information on rights for formal and informal patients. We were unable to see any of the QR codes displayed on the day of the visit. We were told, and saw, that one of the individuals in the ward regularly removed information from the walls. We discussed with the SCN the importance of staff having regular follow up discussions with individuals regarding rights, due to the lack of information available and to ensure rights-based care was being actively promoted. We discussed with the CNM and SCN that in other areas of NHS Lothian there was a care record titled 'rights read' which promoted discussion regarding rights. The SCN agreed that promotion of rights-based care was a priority and would liaise with quality improvement team and other services across NHS Lothian to ensure this was delivered to all individuals.

We noted that each detained individual received a letter from medical records following their detention under the Mental Health Act. This 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 was 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 specified on the day of the visit. We found all documentation completed, recorded on TrakCare and regularly reviewed.

When we are reviewing individuals' 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. During discussions with individuals and on review of care files, we saw three copies of advance statements. Some of the individuals we spoke to were aware of advance statements however, had chosen not to complete one; others were unaware of these. 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 community meeting, 'The Meadows Mingle', which took place regularly in the ward, organised by nursing staff. 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 the minute and agenda of the most recent meeting where individuals had raised issues, such as increased activities on the ward and more artwork placed on walls. The minutes were sent to the SCN who made a time to discuss the issues raised with the individuals on the ward.

We were told that advocacy was provided regularly in the ward by the service, Advocard. 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.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals have their human rights respected at key points in their treatment.

## Activity and occupation

We heard from the SCN that the recreational assistant who provided the activity in Meadows Ward had left and that the ward had had no dedicated recreational nurse for some time. We heard from individuals and saw in care records that there was a lack of planned activity. We saw and heard that there were some opportunities for individuals to engage in activities however, it was not regular and was dependent on staffing levels to support activity. We heard that it was rare that staffing levels allowed staff to arrange regular planned activity. This resulted in individuals reporting feeling "bored" and having long periods during the day with no planned activity.

The information board in the ward provided details on activities that took place at the HIVE, a day service run by SAMH, that is situated in the grounds of the Royal Edinburgh Hospital and that offers a variety of activities and groups. Individuals could attend the HIVE, although this was dependent on risk assessment and pass time off the ward. We also heard that some individuals attended the gym in the hospital site and the OTs offered groups out with the ward,

such as pottery. We heard that the ward had a volunteer who attended regularly with a therapet. Individuals spoke positively about the therapet who attended the ward.

We discussed the lack of activity with the CNM and SCN. We were encouraged to hear that the recreational nurse post has been advertised and it was hoped that a new worker would be employed imminently. Nevertheless, we would expect individuals in Meadows Ward to have access to regular activities to maximise therapeutic benefits, improve mental well-being, increase social interactions, and reduce stress and distress.

**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 saw that there were areas of the ward that needed repair and the décor to be refreshed. The SCN told us that the ward was due to be painted, which will promote a brighter and more welcoming environment. We saw that since the previous visit, there was less artwork on the walls making the environment look more clinical. We heard from staff and individuals that the environment had been regularly damaged by individuals experiencing periods of stress and distress. We saw that where possible, efforts had been made to create more therapeutic spaces for individuals to use. We heard that all repairs had been reported to estates and it was hoped the repairs would be completed soon. We heard from the SCN that there were ongoing plans to have artwork on the walls, to promote a more welcoming and therapeutic environment.

The lounge and dining area were situated at the entrance of the ward. Individuals tended to spend a lot of time in these communal areas, and we observed it was busy on the day of the visit, with individuals using the areas to watch TV, have a hot drink, and use the space to meet with family. Individuals were able to use the kitchen facilities to make a hot drink and snack; this is attached to the communal area. There is access to the outside courtyard until midnight. At times during our visit, the noise levels increased in these areas, and it was easy to understand why some individuals found the communal area challenging.

We were able to see some of the individuals' bedrooms. The bedrooms we viewed had en-suite facilities and were personalised.

We have raised in our previous report that there was a contingency bed placed in the quiet room on the day of the visit although not being used. We were told that the bed would be removed, and the quiet room would be developed in a multi-purpose room. We heard and saw photographs of the quiet room being developed into a therapeutic space for individuals and staff to use. We heard that individuals benefitted from having this dedicated space to engage in group activity and one-to-one support. We were disappointed to hear that shortly after the quiet room was developed, a decision was made by senior managers that the room needed to be used for a surplus bed. 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 did not have washing or toilet facilities, compromising the individual's right to privacy and dignity.

We met with an individual who had been in the room and reported it was a negative experience as the room was cold and did not have basic washing and toilet facilities. 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, Meadows 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 ward and in the courtyard. 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 to 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 heard from staff about a recent incident in the Royal Edinburgh Hospital where a staff member had been seriously assaulted when asking an individual to refrain from smoking. This incident had understandably caused staff anxiety when challenging smoking in the ward environment. 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, 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.

We were pleased to hear plans to develop the garden space which will be supported by the Cyrenians. The objective is to a create a therapeutic outdoor space for individuals, staff, and family to use.

**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:**
Senior 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

The majority of the feedback from individuals and the relative/carer was positive about the care they received on Meadows Ward. Staff we spoke with were committed to providing high quality care to the individuals. There was, however, a theme that when staff were feeling

‘stressed’, this had a negative impact on the individual’s experience of care they received and on the communication with relatives/carers. Staff were transparent about the daily challenges they faced working in the ward environment and how this affected their own well-being.

We appreciate the competing demands staff must 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 care provided to individuals to be of a standard as set out by the NMC Code of Practice. We were pleased to hear that staff were being supported to attend regular supervision and reflective practice, as well as ongoing training.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure that there is a system in place for all individuals that is understood and offer 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 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.

**Recommendation 4:**
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, and that all psychotropic medication is legally authorised.

**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:**
Senior 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.

## Contact details

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