Mental Welfare Commission for Scotland

Report on unannounced visit to:
Margaret Duguid Unit, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5EF

Date of visit: 8 July 2024

Where we visited

The Margaret Duguid Unit is a four-bedded ward in the Royal Edinburgh Hospital. The unit provides support and rehabilitation for individuals who have complex mental health care needs and physical frailty.

The unit occupies a former ward on the hospital site, which was refurbished for its current purpose and opened in 2020. The opening of the unit initially enabled some patients who were receiving out-of-area care in other health boards to return to their local area. Since then, the unit has supported individuals transferred from a wide range of other specialties, including from acute general adult wards, forensic services and from other rehabilitation wards.

The Commission last visited the Margaret Duguid Unit in March 2022 on an announced visit, which was our first formal visit to the service. We made one recommendation at that time, which was to promote the use of advance statements and for staff to provide individuals with information and assistance in this regard.

On the day of this visit, we wanted to follow up on the previous recommendation and to hear from individuals about their care and treatment. This visit was unannounced, not due to any concerns about the service, but as part of our routine visit programme, which includes both announced and unannounced visits.

On the day of our visit, there were four people on the ward and no vacant beds.

Who we met with

We reviewed the care records of all four people, two of whom we also met with in person.

No relatives were present to meet with us on the day.

We spoke with the clinical nurse manager and members of the nursing team.

Commission visitors

Juliet Brock, medical officer

Lesley Paterson, senior manager (east team)

What people told us and what we found

Care, treatment, support and participation

The two individuals we spoke with had varying ability to offer feedback on their experiences. Both were unhappy about being in hospital and gave mixed comments about staff and the experience of being cared for on the unit.

The interactions we observed between staff and individuals during this visit were supportive and the nursing staff we spoke with knew the individuals under their care well. We saw examples of thoughtful, person-centred care. This was exemplified in particular by the support being provided to an individual who had suffered a recent family bereavement and the careful planning undertaken by staff to support their attendance at the funeral.

Multidisciplinary team (MDT)

The unit had an MDT consisting of nursing staff, psychiatry and occupational therapy (OT) staff. Since our last visit, a clinical psychologist and, more recently, a psychology assistant had been added to the MDT. We heard about the positive impact of psychology input from both individuals and staff. Additional input from an art psychotherapist has continued.

Referrals were made to other services, such as dietetics, physiotherapy, speech and language therapy and podiatry when required. We also heard that the service had received good support from specialist teams, such as tissue viability and palliative care when this had been required.

Care records

Clinical records were held primarily on the electronic patient record system TRAKcare, with some additional information still remaining in paper files.

The daily nursing entries on TRAKCare provided clear, detailed updates on individual care and we saw evidence of regular one-to-one nursing interventions. Records of one-to-one input from other disciplines including OT, psychology and art therapy were detailed in individual files and we saw examples of comprehensive assessments carried out by each of these disciplines.

In individual records we also found examples of detailed individual formulations, based on discussions in the MDT and recorded by the psychologist.

Participation in activities was recorded by ward staff, OTs and art therapists, as were times when activities were offered but the individual declined to engage.

We saw evidence of attention to physical health needs, with referrals to external specialists when this was required.

Fortnightly MDT discussions and decisions were well-documented on a ward round template, and we heard from individuals that they had the opportunity to join these meetings and were able to meet with the consultant psychiatrist regularly. Three to six-monthly reviews were also carried out for each individual using a rehabilitation integrated care pathway (ICP) and the updates provided in these ICP records were highly detailed, recovery-focussed and provided input from across the MDT.

We found some inconsistency in the specific documents being retained on paper records. For example, 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were stored electronically for some individuals and on paper for others, which in one case was difficult to locate. We suggested to senior staff on the visit that this be reviewed to ensure a consistent approach and that important documents could be easily located when needed.

Care plans

Nursing care plans were recorded on TRAKCare. As on our previous visit, we found that care plans were heavily focused on physical health needs, and we did not see consistent evidence of person-centred care plans focussed on the mental health needs of each individual. Although we saw some evidence of monthly reviews of care plans, this was not consistently carried out across the patient group.

Care plans should be person-centred and address the full range of care needs for the mental health, physical health, and more general health and wellbeing of the individual. The Commission has published good practice guidance 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.

During our last visit we were advised that work was underway in NHS Lothian to revise the design of care plans on TRAKCare in order to implement a format better suited to the needs of patients in mental health services. We heard on this visit that a new electronic care plan format had been developed and was about to introduced across the hospital, with staff training due to commence in the coming weeks.

We look forward to monitoring progress of this care planning initiative across the mental health service and to reviewing the resulting care plans in future visits to the unit.

Use of mental health and incapacity legislation

On the day of our visit, all the patients in the ward were detained under either the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

Documentation relating to the Mental Health Act and Criminal Procedure Act could be found in the electronic records, with copies also in the paper records. In one case, we found it difficult to clearly ascertain the current legal status of an individual from the clinical record due to a protracted Criminal Procedure Act appeal process and had to clarify this with senior staff.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to individuals who are detained and are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place for all four individuals and corresponded to the current medication being prescribed.

Any person 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 a record of this.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act, 2000 (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. We found section 47 certificates in place for three individuals; these were appropriately authorised and up to date. We could not find individualised treatment plans for two people and suggest this is reviewed by the medical team.

Three of the four individuals on the ward were subject to specific parts of the AWI Act, however it was not immediately clear from the clinical records or from speaking with staff, which legal aspects were relevant to each individual.

A patient information board in the staff office underlined this ambiguity, noting only “AWI” next to individual names, but with no reference to what was meant by this. It appeared that this term was generally used (on the board, and by staff) to identify individuals who had a section 47 certificate authorising medical treatment under the AWI Act. We found that one person was also subject to welfare guardianship, however the staff we spoke with appeared unaware of this, it was not recorded in the key information on the office whiteboard and there was little reference to this in the clinical records, except for a copy of the guardianship order buried in the paper file.

Recommendation 1:
Managers should ensure that when a welfare proxy is in place for an individual, this should be clearly documented and a copy of the powers of the proxy should be held in the care records.

When we asked about this, there appeared to be limited knowledge among staff about the AWI Act and particularly about the role and importance of welfare proxy decision makers (welfare guardians or those granted power of attorney).

We discussed concerns about the understanding of the AWI Act with senior staff at the end of the visit and made recommendations in relation to staff training.

The Commission has worked jointly with NHS Education for Scotland (NES) to develop training in relation to the Adults with Incapacity Act and an eLearning module has recently been launched on TURAS. This can be accessed by anyone in the workforce and has been developed for those working with people aged 16+ years who may be considered to lack capacity to make some or all decisions.

Recommendation 2:
Managers should take steps to improve staff understanding and training in relation to the AWI Act. We recommend the eLearning module on TURAS, which has been developed for informed and skilled levels of practice within the workforce.

Rights and restrictions

Following our last visit, we made a recommendation about promoting advance statements. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act, which are written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility to promote advance statements.

We heard that a piece of work had followed the Commission's recommendation and that this had involved awareness raising among staff about patient rights, advocacy and advance statements. We were told the awareness raising had included sessions run by Advocard, the independent advocacy service based in the hospital, and the Patients' Council.

We did not see evidence of advance statements in the records we viewed, and staff were not aware of these being in place. One individual, who was in the process of discharge to the community, had heard of advance statements and expressed an interest in making one. We discussed this with staff on the visit.

Recommendation 3:
Managers should ensure staff continue to promote the use of advance statements and engagement with advocacy service. These discussions should be documented in the care records.

We asked the staff about advocacy and were told that the patients were able to access independent advocacy from Advocard. One patient we spoke with said they were unaware of this, and they were keen to be referred for advocacy support.

When we contacted Advocard following the visit, we heard positive feedback from the advocacy team. Despite there being a limited number of people on the ward, they had supported a number of individuals over time and the feedback about the ward and staff had been positive.

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 this and where restrictions are introduced, it is important that the principle of least restriction is applied.

No individuals were subject to specified person restrictions at the time of this visit, although we saw evidence of appropriate documentation having been completed in relation to previous restrictions in individual cases.

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.

Activity and occupation

We received some feedback from individuals about the activities on offer, both in the ward, on the wider hospital site and with passes to the community.

We heard from staff about the support from OT, art and music therapy in providing a programme of activities, often on a one-to-one basis, to suit each individual's needs. Ward staff also supported activities, and we were told that staffing levels usually enabled them to take people out on a daily basis, whether in the hospital grounds or the local area. There were also regular visits from a therapet.

In the clinical records we found evidence of a range of activities and therapies being offered. For those able to participate, the OT offered regular sessions in the OT kitchen just off the ward and we heard from one person who had unescorted passes that they were able to go food shopping every week in preparation for this. We also saw evidence that activities were discussed in MDT meetings and reviewed during the ICP process; in one case, for example, plans were recently agreed to explore options to access swimming in the community, in accordance with the individual's interests. For those who were physically frail and more limited to the ward environment, effort and attention was made to engage them in meaningful activity that was accessible to them.

The physical environment

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

The environment was clean and well-maintained, and we noted that since our last visit, a variety of artworks had been acquired for the hallways and communal areas which went some way to making the environment feel less sterile and clinical.

Individual bedrooms, each with en-suite shower rooms, were large, spacious and were able to be personalised. There was an assisted bathroom on the ward for those preferring a bath.

The main communal area was the large dining room, with four round tables and chairs. As well as a few pictures and a wall with a large weekly timetable and colourful posters advertising activities on offer within the hospital, one wall had a large television. We were told this was the main area patients used if they wished to watch TV together.

There was a small sitting room with armchairs and a small table which we were told was used mainly when individuals had visitors or wanted to meet with family outside of their bedroom. There was a family room on the ward which, during our last visit was being used as a storeroom, and, on this visit was in the process of being renovated into an office for staff.

The large therapy room had a range of art supplies and music equipment and was clearly well used, as evidenced by the multitude of artworks created by one of the individuals on the ward who we were told was preparing for an exhibition. The multi-purpose space was also utilised for MDT meetings and had a wall mounted television so that patients could also use it as an alternative TV lounge on occasion if they wished.

The ward had a laundry room which could be accessed by individuals as part of their OT rehabilitation, as well as access to the OT kitchen adjacent to the ward.

At the end of the ward there was access to a shared courtyard space. We did not see the outdoor space on this visit but were pleased to learn that more seating and plants had been introduced and that it continued to be accessed and well used by individuals on the unit.

Any other comments

At the last visit, we heard from the team that staffing was a challenge, and that the unit was providing a service with less than the full complement of trained nursing staff.

On this visit we heard that although sickness levels on the unit were high, staffing had been less of a challenge, with good availability of staff familiar with the unit on the staff bank when needed and no use of agency staff being required.

A new senior charge nurse had recently joined the team and a second charge nurse had also recently been appointed. We heard that the senior nursing team now brought a broad range of expertise, including from general nursing, forensic mental health and the management of violence and aggression. Given the complex nature of the mental health needs, behaviours that challenged and physical frailty of individuals often managed by the service, this range of experience was welcomed.

Summary of recommendations

Recommendation 1:
Managers should ensure that when a welfare proxy is in place for an individual, this should be clearly documented and a copy of the powers of the proxy should be held within the care records.

Recommendation 2:
Managers should take steps to improve staff understanding and training in relation to the AWI Act. We recommend the eLearning module on TURAS, which has been developed for informed and skilled levels of practice within the workforce.

Recommendation 3:
Managers should ensure staff continue to promote the use of advance statements and engagement with advocacy service. These discussions should be documented in the care records.

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

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