Mental Welfare Commission for Scotland

Report on announced visit to:

Cedar and Hawthorn Wards, The Orchard Clinic, Royal Edinburgh Hospital, Edinburgh EH10 5HF

Date of visit: 9 & 10 October 2023

Where we visited

The Orchard Clinic is a 40-bed, medium secure forensic unit on the Royal Edinburgh Hospital site. In addition to an acute admission ward, there are two forensic rehabilitation wards in the clinic. Cedar is a 14-bed rehabilitation ward for men. Hawthorn is a mixed-sex-11 bed rehabilitation ward.

We last visited the rehabilitation wards at the Orchard Clinic in September 2022 and made recommendations about improving and auditing nursing care plan reviews, ensuring a reasoned opinion and required documentation was in place for individuals who were specified persons, ensuring access to therapeutic activities and upgrading and developing the shared garden space.

On this visit, we wanted to follow up on previous recommendations and to hear about current patient and staff experiences. The visit was carried out over two days, to enable patients on each ward to have plenty of opportunity to meet with us.

At the time of our visit, there were 12 patients on Cedar Ward (where two bedrooms had recently been closed for the repair of water leaks) and 10 patients on Hawthorn Ward.

Who we met with

We met with and reviewed the care notes of six patients on each ward.

We spoke with the service manager, clinical nurse manager, senior charge nurses, consultant psychiatrists, peer support worker, clinical pharmacist and a number of staff on both wards.

Commission visitors

Dr Juliet Brock, medical officer

Gillian Gibson, nursing officer

Gemma Maguire, social work officer

What people told us and what we found

Care, treatment, support and participation

The individuals we spoke with on both wards were very positive about staff and the care they were receiving.

On Hawthorn, individuals told us that staff were supportive, accommodating and took time to listen to them. They said that staff were caring and friendly and always asked how they were doing and that they felt safe on the ward. In one person's words "the staff are nothing but helpful, I've nothing but good things to say about them… they try to support activities when they can".

On Cedar Ward the patients we spoke with told us that the staff were 'great' and they commented that there was a good range of activities on offer. One person said of their experience on Cedar "there are good staff who really know me well and I trust". A number of people who had previously received care in the high secure setting of the State Hospital also spoke favourably about their care on the ward, and were positive about the transition to medium secure care. A few people on Cedar did comment that there did not always seem to be enough staff; there seemed an awareness among the patient group of nursing shortages.

We had known for some time of staffing pressures across the clinic and the considerable challenges that this was placing on the ward staff teams.

On this visit, we heard from the team on Cedar Ward that staffing levels did remain a challenge, though this was said to be improving slightly. The staff complement was at 50% at the time of our visit, with regular staff often helping to cover shifts. Additional support from the staff bank, and occasionally from agency staff, was at times required. This posed additional challenges as agency staff (and sometimes new bank staff) did not have access to the electronic system, TRAK and were unable to assist with some patient escorts/passes.

We heard there had been some recent departures of staff from the team, but also that a number of new staff had joined. It was good to hear that initiatives such as the joint Open University and NHS Lothian nurse training programme 'earn while you Learn', which offer qualifications to staff nurse level after four years clinical experience.

We also heard from the staff on Cedar Ward that colleagues from psychology and psychiatry (from junior medics to consultants) had been increasingly present on the ward to support nursing colleagues, particularly to assist with activities and taking patients out on pass. This support had been greatly valued.

On Hawthorn Ward, less concern was voiced about staffing levels. Two new staff had recently joined the team and staff morale was said to be improving after a difficult few years.

Multidisciplinary team (MDT)

In addition to medical and nursing staff, both wards had input from occupational therapy (OT) and psychology, along with art and music therapists. The peer support worker continued to provide input to the wards and both patients and staff continued to reflect positively on this support. The clinical pharmacist working in the clinic also attended MDT meetings. Input from

other professionals such as dietetics and physiotherapy was available on referral. In addition, clinical teams had input from social workers based in the clinic.

Each multidisciplinary team had a nominated consultant psychiatrist and carried out clinical team meetings for their rehabilitation patients on a fortnightly basis; each rehabilitation ward held two (fortnightly) clinical team meetings per week.

Previously there was a GP attached to the clinic who carried out surgeries on a regular basis. The post was vacant at the time of our last visit and unfortunately the situation was unchanged on this latest visit.

Given that individuals may receive care in the rehabilitation wards for a number of years, the monitoring of their physical health needs, including inclusion in routine screening, is particularly important. We were told that junior doctors on both wards carried out physical health reviews as required, in addition to annual monitoring, though the recording of annual checks and screening was reportedly charted on boards in the doctor's office and not in the clinical records. We discussed this on the day, and emphasised the importance of ensuring a reliable system of physical health monitoring and recording in patient records.

Recommendation 1:
Managers should ensure that a robust system is in place to monitor the physical health of individuals in the clinic, with annual physical health reviews (including screening where applicable) clearly recorded and easily accessible in patients' records.

Care records

As detailed in previous reports: patient records were held mainly on TRAK, the electronic health record management system used across NHS Lothian. Additional documents, including nursing care plans and Care Programme Approach (CPA) records, continued to be held on the clinic's shared drive, with some copies held in paper files.

We shared concerns with managers about the potential risks introduced by holding different parts of patients' clinical records in different places. We were assured that this issue was already under review by senior managers, who were working in conjunction with digital and clinical governance teams in the health board.

In the patients' records we reviewed, we found that in general, the daily care notes contained a good level of detail, including documentation of individual participation in activities. We also saw detailed entries from other professionals in the MDT, including OT and psychology, as well as evidence of assessment and review by physiotherapy and dietetics, where indicated.

On both wards, we found that the recording of clinical team meetings (CTMs) was variable. In some individual records we could also find no evidence of a CTM taking place for over a month. There was not always evidence of multidisciplinary input into the CTM discussion, or of patient participation, though individuals on Hawthorn Ward spoke positively about participation in these meetings and told us they felt involved in decision making about their care.

There was evidence of three to six monthly CPA meetings, with copies of documentation, which was very detailed, held on the clinic's internal shared drive.

We were concerned not to find records of annual physical health checks in the notes we viewed. We were pleased to learn however that a quality improvement project, initiated by the clinical pharmacist, was underway to look at improving the monitoring of patients on high dose antipsychotic medication. We were also advised of plans for further development of physical health monitoring for patients attending the clozapine clinic (through the provision of a new advanced nursed practitioner post).

We look forward to hearing more about progress in these areas on future visits.

Nursing care plans

We were encouraged to hear positive feedback about participation in care planning, with individuals telling us they had a good understanding of their care plans, that they had been involved in developing these, and of their individual recovery-focussed goals.

In the files we viewed on both wards, nursing care plans were generally person-centred, with clear goals, though the quality of reviews was variable. Reviews, when carried out, were not always looking at the efficacy of interventions or progress towards a goal. This was similar to findings on our previous visit, when we had made a recommendation for audit. We heard that a piece of improvement work focussing on nursing care plans was ongoing, with input from staff from each ward across the clinic, but that progress had been slow.

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:
We repeat previous recommendations that managers should carry out an audit of nursing care plan reviews, to ensure these fully reflect patients' progress towards stated care goals and that recording is consistent across all care plans.

Use of mental health and incapacity legislation

All patients in the clinic are detained under the Criminal Procedure Scotland Act 1995 (CPSA) or the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

All documentation relating to the Mental Health Act and CPSA was in place in the files we reviewed, and the patients we met with had a good understanding of their detained status.

Part 16 of the Mental Health Act sets out the conditions under which medical treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. Previously, consent to treatment forms (T2s) and certificates authorising treatment (T3s) had only been accessible electronically via TRAK. This had meant that cross-checking treatment authorised under the Act with medication prescribed (on the hospital electronic prescribing system, HEPMA), for any individual required simultaneously navigating two different electronic databases, which often posed a challenge. We had previously been told (elsewhere) that it was not possible to upload details from T2 and T3 forms onto HEPMA.

We were impressed therefore to note that a significant piece of work had been carried out by the clinical pharmacist, in collaboration with medical staff in the clinic, to upload information about treatment authorised on each person's T2 and/or T3 onto HEPMA. This was the first time we had seen this done. We noted that some further work was needed (for example to change automated references from the English to the Scottish Mental Health Act on the system) but the work that had already completed enabled swifter and easier checking of any medication prescribed to ensure this was properly authorised under the Act.

We found that appropriate T2 and T3 documentation was in place and corresponded to the medication being prescribed in all but one of the cases we viewed. We highlighted the exception with staff on the visit so that corrective action could be taken.

One of the patients we reviewed had a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act, as they lacked capacity to make decisions about medical treatment. This certificate, required by law, was correctly completed and we also found appropriate documentation in place for covert medication to be given to this person.

We were pleased to hear that a quality improvement project, initiated by the clinical pharmacist, was underway to look at improving the monitoring of patients on high dose antipsychotic medication, and that plans were also underway (through the provision of a new advanced nursed practitioner post) for further development of physical health monitoring for patients attending the clozapine clinic. We look forward to hearing about further progress in these areas on future visits.

Rights and restrictions

There was awareness of the role of independent advocacy among the individuals we met with on Cedar and Hawthorn. The staff teams on both wards also spoke positively about the role of advocacy and how proactive the hospital advocacy service, Advocard, was in engaging the patient group. We heard about plans for regular drop-in sessions that were soon to start on the wards.

We heard from one person about how advocacy had supported them to raise specific dietary concerns, and how the staff team were working collaboratively with them to address the issue.

On Hawthorn Ward, there was a monthly community meeting for patients, where any areas of concern or recommendations for improvements on the ward could be raised with the staff team. We heard this meeting was well attended and that recent outcomes had included the purchase of an X-box for one of the lounges and the introduction of more cooking sessions, at the request of the patient group.

On Cedar Ward, three patients raised issues with us about a lack of food choices and repetitive menus. They said they were unaware of how to raise concerns or of any group forums for this. We heard that there were dates planned for group advocacy sessions, run by the hospital's Patients Council that patients could access. A process was in place for feedback from this meeting to clinic managers, although concerns about protecting patient anonymity had been raised as a concern by the Patient Council representative in the past.

One patient made a suggestion to us about starting a group to represent the views of patients from all three wards. We discussed this further with managers at the end of the visit, including the potential scope for a patients' forum from across the clinic to raise issues for consideration by managers; the service plan to look further at options for patient feedback.

Where individuals were subject to specified person restrictions under the Mental Health Act, we found appropriate documentation in place to authorise this.

When we asked about advance statements, some patients told us they had one in place, while others had not heard of them. The term 'advance statement' refers to written statements made under ss274 and 276 of the Mental Health Act. These statements are written when a person has capacity to make decisions about the treatments they do and do not wish to receive in the future. Health boards have a responsibility for promoting advance statements.

We also wished to note a significant piece of joint work carried out by the social worker and ward staff to support one individual with parental contact, to help develop a meaningful relationship with their child. This joint work had involved careful risk assessment and family liaison. There was clear evidence from interview and from clinical records of rights-based principles being applied in considering both each young person's needs and views, and balancing these with each adult's parental rights, which advocacy helped them to exercise. Supporting people who are detained in hospital with their right to a family life, particularly in respect of patients who are parents, is important. This is an area which the Commission will be looking at in more detail in the near future.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

On the last visit, we noted that for patients with limited passes, particularly those in Hawthorn Ward, opportunities for therapeutic activities could be limited, and that although ward staff tried to facilitate activities on the ward, this could be limited due to staffing pressures. We made a recommendation that managers review the opportunities for patients on Hawthorn Ward to engage in therapeutic activities and to consider the need for an activity coordinator. Given existing input from occupational therapy across the clinic, the service did not consider this additional role to be required.

On this visit we were pleased to hear positive feedback about activity provision, particularly from those in Hawthorn Ward. Individuals told us that there was always something to do and they were not bored although we heard that, at times, staff shortages did impact on activities and access to passes for those requiring to be escorted.

People told us about a range of activities in Cypress Unit run by OTs and therapists. Patients' spoke of enjoying cooking sessions, art and music therapy, and physical activities in the gym hall such as badminton and bowls. However, it was raised with us by one person that opportunities for exercise were limited and that the lack of sport and physical activity was detrimental to recovery. We heard from staff that some previously run groups in the clinic such

as a fitness group, football and basketball sessions had ceased due to re-assessment of risk and lack of trained supervisors. We were told of proposals for a quality improvement project by the OT team to look at patient's broader physical health needs.

Education was also supported though both online resources and there was access to studies through Edinburgh College. We heard examples of this, with one person speaking about the astronomy course they were doing via the Open University and another working towards a John Muir award with Edinburgh College.

It was encouraging to hear about the Recovery café, co-facilitated by the peer support worker and OT. This six-week programme, based on work of the Scottish Recovery Network, was open to patients from both Cedar and Hawthorn Wards. We also heard of plans in the near future to start a further joint group with OT, focussing on Wellness Recovery Action Plans.

We heard positive feedback about the continued range of activities available in the wider hospital and grounds, such as the Cyrenians gardening project, as well as a programme of activities at the Hive, gym sessions in the main hospital and a number of individual activities, such as library sessions, supported by the hospital's volunteer hub.

We did however also hear from patients and staff about the impact of nursing pressures on activities at times. Patients were sometimes frustrated at not being able to access their escorted passes, but, given their awareness of staff challenges, were reluctant to ask for this. Some wider concerns were voiced about the ability at times to support patients' rehabilitation needs in this context.

Recommendation 3:
Managers should review the current access to exercise and physical activity for patients across the clinic and, in conjunction with the planned QI project in this area, consider further initiatives to optimise opportunities for physical fitness and wellbeing.

The physical environment

Cedar Ward

Although on our last visit we noted that the communal areas in Cedar Ward had been freshly painted, with new furniture in situ, on this visit the ward while we found that the ward was clean, the environment appeared tired in places and would benefit from a refresh. A number of patients and staff also commented about the poor state of the recently replaced furniture in communal areas, with chairs being ripped. The replacement with new furniture was planned and should be a priority. The quiet room on the ward provided a separate area for people to sit and relax away from the main TV lounge.

Hawthorn Ward

The environment on Hawthorn was clean and freshly painted. In addition to the main TV lounge, the separate lounge at the back of the ward, which had previously been decorated by one of the staff, was a well-used space. A further quiet room on the ward, again decorated and furnished by staff, provided more of a homely space to relax.

Patient bedrooms

The bedrooms on both wards have en-suite shower areas. At the time of publishing the last report, we were advised that the long-awaited refurbishments to en-suite facilities across the clinic was about to start. These upgrades were needed to reduce potential ligature risks in patient bathrooms, in line with the design in newer wards across the hospital. By the time of this visit, a phased schedule of works across the clinic was planned and due to start in Redwood Ward.

While these upgrades remained pending, during this visit we recommended the replacement of shower curtains in some areas of the rehabilitation wards (including en-suite shower rooms in Cedar and the shared bathroom on Hawthorn) as these appeared in a poor, unhygienic state.

It was also brought to our attention on this visit that patients had limited opportunity to personalise their bedroom space. Putting pictures on the walls, for example, was said to be discouraged. Given that many patients may spend several years on the rehabilitation wards, we would encourage senior charge nurses and managers to consider how patients may be enabled to personalise their bedroom environment, should they wish to do so.

Shared garden

The outdoor garden space, shared between the two wards, continued to be well used by patients and staff.

On the last visit we commented that the overall appearance of the garden furniture, paved areas and external woodwork in this space was quite tired and somewhat neglected. We made a recommendation to managers to upgrade the outdoor area and to work with patients to "develop ideas to maximise use of the recreational outdoor space to best meet the needs of the patient group".

We recognised on this visit that the staff teams had made some efforts to tidy the space and improve the general appearance of the shared garden. However, it continued to look tired and would have also benefitted from additional seating. The space continued to compare poorly with gardens available to many other in-patient wards on the hospital site.

The large adjoining outdoor basketball court was also in need of attention and had now been unusable for several years. This had been for safety reasons, due to a surface covering of moss which we were advised required specialist cleaning. We were pleased to learn that, following the Commission's last visit, managers had set up regular meetings with the hospital Estates department to ensure a rolling programme of basic maintenance across the clinic (such as window cleaning and the clearing of gutters) and that the issue of upkeep of the outdoor courts was also being addressed. Unfortunately, we were told it had proved challenging to find a company to carry out the works, which had meant another summer without the basketball court being in use.

Given how well used and how popular the outdoor courts used to be - there is also a separate one attached to Cypress - together with the interest expressed among the patient group for better access to outdoor physical activity, we continue to see this as an area that should be prioritised for funding and improvement work.

Recommendation 4:
Managers should work with the estates department to prioritise the improvement of outdoor areas in the Orchard Clinic, so that these offer safe, accessible and welcoming garden and recreational spaces for patients to use and enjoy.

Summary of recommendations

Recommendation 1:
Managers should ensure that a robust system is in place to monitor the physical health of individuals in the clinic, with annual physical health reviews (including screening where applicable) clearly recorded and easily accessible in patients' records.

Recommendation 2:
We repeat previous recommendations that managers should carry out an audit of nursing care plan reviews, to ensure these fully reflect patients' progress towards stated care goals and that recording is consistent across all care plans.

Recommendation 3:
Managers should review the current access to exercise and physical activity for patients across the clinic and, in conjunction with the planned QI project in this area, consider further initiatives to optimise opportunities for physical fitness and wellbeing.

Recommendation 4:
Managers should work with the estates department to prioritise the improvement of outdoor areas in the Orchard Clinic, so that these offer safe, accessible and welcoming garden and recreational spaces for patients to use and enjoy.

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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