Mental Welfare Commission for Scotland

Report on unannounced visit to:

Royal Edinburgh Hospital, the Robert Fergusson Unit, Morningside Terrace, Edinburgh, EH10 5HF

Date of visit: 12 July 2016

Where we visited

The Robert Fergusson Unit is the Scottish Neurobehavioural Rehabilitation Service national inpatient unit. It principally provides inpatient rehabilitation for people whose symptoms after acquired brain injury include severe behavioural disturbance. A smaller number of patients have progressive neurological problems, e.g. Huntington's disease. Some patients have complex physical healthcare needs.

There is a 12 bedded ward for men on the ground floor. There were nine patients on the day of the visit.

There is a seven bedded unit on the second floor. On the day of the visit there were six patients – five women and one man.

We last visited this service on 9 April 2014 and recommended that:

- Prescriptions for medications given by percutaneous endoscopic gastrostomy (PEG) tube should state this route of administration.

- Episodes of restraint should be monitored and a significant episode of restraint should lead to the patient being assessed to determine whether they require to be detained under the Mental Health Act (Care and Treatment) (Scotland) Act 2003.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with and or reviewed the care and treatment of 11 patients. We also met with relatives of one patient.

We spoke with the consultant psychiatrist, speech and language therapist, charge nurse and other nursing staff on each ward.

Commission visitors

Dr Mike Warwick, medical officer (visit coordinator)
Dr Gary Morrison, executive director (medical)
Moira Healy, social work officer

What people told us and what we found

Care, treatment, support and participation

Some patients we met were able to have more discussion with us than others. All those who could tell us about their experiences in the ward made positive comments about staff and the support they receive from them. The relatives we met gave very positive feedback about the care their relative is receiving and felt involved by staff.

The atmosphere in both wards was calm. Patients seemed comfortable in the company of staff and happy to approach them. We saw staff being very proactive in engaging with patients. All interactions we saw were warm, friendly and respectful. We saw patients going off the ward in the company of staff during our visit.

Staff were very knowledgeable about patients. It was apparent that the team provides highly person-centred care.

Patients have pictorial orientation guides on the walls in their bedrooms, which is good practice.

Multidisciplinary input

The unit has a well resourced multidisciplinary team (MDT) including: nursing staff; input from two consultant neuropsychiatrists and an associate specialist in neuropsychiatry; speech and language therapy; occupational therapy; physiotherapy; art therapy and social work.

The speech and language therapists are currently involved in developing training materials for staff on the Scottish Acquired Brain Injury Network (SABIN) website. This will no doubt be a valuable resource, and we were interested to be shown this.

Multidisciplinary review and documentation

Case notes were well organised and we could easily find documentation and reports by different disciplines.

We saw ‘Getting to know me’ proformas completed with good detail about patients’ personal histories, which is clearly important information to inform person centred care.

Nurses complete care rounding documentation for each patient during the day. This documentation has been developed particularly for the unit, and includes monitoring of behaviour.

A ward round is held weekly, attended by the full MDT and patients. A record of this meeting is typed on a clear proforma for each patient, with an attendance list, and filed in their notes. This is good practice.

The consultant and nursing staff hold a focussed intervention meeting weekly. From this, a current focus plan, on a single sheet of A4, is developed for each patient and reviewed every few months (or six-weekly for some patients). This is very clear and goal orientated. Goal planning meetings are also held, where nursing care plans are reviewed. These progressive support plans and maintenance support plans were detailed and person centred.

The MDT holds a case conference for each patient three-monthly.

Throughout the notes we found evidence of detailed assessment and development of person-centred care.

There was evidence of staff having regular contact with patients' families.

Prescribing of medications by PEG tube

Where patients had PEG tubes inserted for nutrition and were receiving medication via this route, this was appropriately specified on the medication prescriptions.

Admissions and moving people on

There were no patients classified as delayed discharges. Some people have been in the unit for long periods. Due to the fact that it is a national unit, some patients are a long way from home and relatives can have a long journey to visit. The relatives we spoke to were in this position and discussed this with us.

Staff discussed with us how, due to the complexity of their needs, there are no services in some patients' home areas that could provide the care they will require.

A discharge coordinator is soon to start work across the inpatient rehabilitation service.

Staff told us that referrals to the service tend to be people who would require 1:1 or 2:1 care. They said that they do not feel they have the staffing resources to admit more patients who require this level of care at this time.

Use of mental health and incapacity legislation

Mental Health Act matters

Patients who require frequent restraint as part of their care and treatment were detained under the Mental Health Act. This affords the patient the safeguards of the legislation, and is good practice. Incidents of aggression are reviewed at the weekly ward round and the need for use of the Mental Health Act is kept under review.

All detained patients who required a 'certificate authorising treatment form' (T3) for medication had one on place. A T3 is a certificate issued by a designated medical practitioner to authorise treatment under the Mental Health Act. One patient was prescribed one medication that was not included on their T3. We raised this with

their consultant psychiatrist on the day and they requested a visit by a designated medical practitioner.

Two patients were prescribed ‘if required’ psychotropic medication with potential for this to be given at doses beyond those authorised by their T3. We discussed this with the consultant psychiatrist and said that it is helpful and important for the responsible medical officer to clearly inform the DMP if they are requesting authorisation to prescribe medication at doses/frequency outwith British National Formulary recommendations.

Adults with Incapacity (Scotland) Act 2000 – welfare guardians

The notes for two patients we saw who had welfare guardians did not contain a copy of the welfare guardianship powers.

Recommendation 1

Ward staff should ensure that, if a patient has a welfare guardian, they obtain a copy of the welfare guardianship order and file this in the patient’s notes.

Adults with Incapacity Act – s47 certificates

We were pleased to find s47 certificates in place. However, we saw s47 certificates that contained general entries that did not cover medical conditions that the individual was receiving treatment for. Individual conditions/interventions need to be specified on the S47 certificate itself, or on an attached treatment plan unless they are covered by an entry for ‘fundamental healthcare procedures’. Where a treatment plan is used, this should be referred to on the s47 certificate. This is explained in the Code of Practice for Part 5 of the Adults with Incapacity Act:

http://www.gov.scot/Publications/2010/10/20153801/0

Some s47certificates for detained patients contained treatment for mental health conditions. Treatment authorised under the Mental Health Act cannot be included on a s47 certificate.

One s47 certificate had expired.

Recommendation 2

Managers should ensure that medical staff are trained in correct completion of Adults with Incapacity Act s47 certificates and treatment plans. All medication that a patient is receiving under the Adults with Incapacity Act should be properly covered.

Rights and restrictions

Due to the needs of the patient group, the doors of the wards are locked. Patients who are able to leave can ask staff to do so. The downstairs ward has a safe

enclosed garden with access from the main sitting area of the ward. This is also used by patients from the upstairs ward.

One individual who was informal was prescribed intramuscular (IM) medication if required. We have concerns about IM 'as required' medication being prescribed for informal patients. We discussed this with the consultant psychiatrist. They explained that this would be used in only exceptional circumstances, following which they would review whether the patient required to be detained under the Mental Health Act. We have written to the consultant with some further advice about care planning for this situation, and for review by the duty doctor should IM medication be required.

Activity and occupation

We saw a strong emphasis on socialisation in patients' care plans. We saw people being escorted off the ward by staff during the day of our visit. Activities patients are supported to participate in include walks, outings in the minibus, shopping and meals out.

Therapeutic groups were provided in the past, but now the only group is an art therapy group. Staff told us that this is because current patients need mainly 1:1 input and would not manage group work. The occupational therapist provides 1:1 input for patients.

Staff told us that the occupational therapists are liaising with the volunteers hub.

The physical environment

The Robert Fergusson Unit wards are old wards in Mackinnon House that are not fit for purpose. This is well recognised by NHS Lothian. Prior to our last visit, the service undertook considerable refurbishment of parts of the unit to improve the environment as far as possible.

The service will move to the new unit in the new Royal Edinburgh Hospital in February 2017. This is very welcome, and will be very beneficial for patients and staff.

There is only one issue concerning the current environment that we recommend should be addressed to allow appropriate care of patients in the unit for the time it remains open.

In the downstairs ward there is only one bathroom operational (it has a bath and a shower). The bath in the other bathroom had to be taken out and cannot be replaced. Installing in a walk-in shower in that room is being considered.

Recommendation 3

Managers should update the Commission on whether a shower will be installed in the decommissioned bathroom in the ground floor ward.

Summary of recommendations

1. Ward staff should ensure that, if a patient has a welfare guardian, they obtain a copy of the welfare guardianship order and file this in the patient's notes.
2. Managers should ensure that medical staff are trained in correct completion of Adults with Incapacity Act s47 certificates and treatment plans. All medication that a patient is receiving under the Adults with Incapacity Act should be properly covered.
3. Managers should update the Commission on whether a shower will be installed in the decommissioned bathroom in the ground floor ward.

Good practice

There is excellent multidisciplinary review and person-centred care planning.

The 'current focus' single-page plan for each patient provides a clear goal and action plan.

Service response to recommendations

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

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Mike Diamond

Executive Director (Social work)

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 MWC 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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