Mental Welfare Commission for Scotland

Report on announced visit to:

Cramond Ward, Royal Edinburgh Hospital, Edinburgh EH10 5HF

Date of visit: 9 November 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Cramond Ward was opened in 2020. It is a 13-bedded, mixed-gender intensive rehabilitation ward that provides treatment for adults, usually between the ages of 18 and 65, who have ongoing complex care needs and have required secure environments. The ward provides relational security, and although it is not considered a secure environment, the purpose of the service is to provide rehabilitation and safety for those on the ward. This was the first time the Commission has visited Cramond Ward.

Who we met with

We met with eight patients and reviewed their care. We also met with one carer.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), staff nurses, recreational assistant and music therapist.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support and participation

Comments from the patients

Throughout the visit we saw kind and caring interactions between staff and patients. The atmosphere in the ward was calm and welcoming. Staff spoken with knew the patient group well and appeared committed and motivated to support the patients. It was positive to note that patients we met with praised the staff highly, with one patient commenting “they go above and beyond to care and support me”.

The patients we met on the day of the visit were extremely positive about their care and treatment. The feedback included comments such as “staff are caring and supportive”, “I’m able to give my views and I feel listened to” and “I feel safe in the ward”. Those who we spoke with told us about their activities in the ward, and were positive about the impact of these, especially the community outings arranged by the recreational workers, art therapy and the input from the occupational therapist (OT). We also heard that patients were happy with the introduction of music therapy sessions that had started on the day of the visit.

Patients told us that they had a key nurse who they met with regularly; we heard that they had regular reviews by their responsible medical officer (RMO). Patients told us that they felt very involved in discussions and decisions made about their care and viewed this as positive. Most of them had some awareness of discharge planning, while others were able to identify that they still had some goals to achieve before their discharge plans progressed.

We met with one carer on the day of the visit. The carer told us that staff communicated with them regularly, to provide updates on the person they care for. We heard that staff are “friendly and approachable”. The carer told us that they were invited to attend meetings and felt involved in discussions and decision-making.

Staff told us that the team in Cramond Ward were supportive of each other, and this created a positive working environment. Staff told us that they have developed therapeutic relationships with patients which was essential in a rehabilitation service. Staff also praised the ward management team. We heard from staff that they felt listened to and supported in their own development. We heard about various mental and physical health training courses for staff that have promoted skill development. We also heard that there were monthly staff team meetings and one-to-one appraisals. The SCN told us that staff had the option to attend reflective practice sessions arranged by psychology. There was additional support for newly qualified nurses provided by a clinical educator.

Although staff morale was generally good, we were told by staff that the ward had experienced staff shortages and there were nursing staff vacancies. The ward used bank staff regularly. The bank staff who cover shifts were routinely covered by the same bank staff which offered some continuity for patients. The CNM told us that there had been initiatives to support recruitment such as modern apprenticeships that offered work experience, development of nursing skills and access to practical learning while studying

Care record

Information on patients care and treatment is held electronically on TrakCare; we found this easy to navigate. The case records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in Cramond Ward. We found the quality of information recorded in the case notes variable. Some of the case notes we reviewed evidenced person-centred care and had individualised information, detailing what activities the patient had engaged in that day and what had been positive or challenging. Other case records contained limited detail that was not personalised to the patient, and lacked the patient's perspective.

It was evident from reviewing the case records that patients in Cramond Ward require high levels of care, motivation and support, with each of multi-disciplinary team (MDT) involved in providing the care and treatment to patients. However, the notes did not provide evidence of regular one-to-one interactions between the patients and nursing staff. We raised this with the SCN on the day of the visit who confirmed that nursing staff did have regular one-to-one interactions with patients, however there was no specific section on TRAKCare at present to record this. The SCN told us that currently, there is a quality improvement project taking place to review how rehabilitation services record information on TRAKCare. One of the aims of the project is to encourage and improve the documentation of one-to-one interaction with patients.

We were pleased to find that the case notes included regular communication with families and relevant professionals. We saw referrals to community-based services for many patients and for those moving towards discharge, there was evidence of communication with GP practices.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care. Good care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made. The Commission would expect a rehabilitation service to have care plans based on a whole-systems approach, with a clear focus on recovery. We were pleased to find that the care plans were individualised, goal-focused, person-centred and adopted a holistic approach. There was evidence of high levels of involvement from the patient. All of the patients we met with told us that they had been actively involved in compiling their care plans and had added personalised information, such as how they liked staff to communicate with them and how they felt best supported.

We would expect a rehabilitation care plan to focus on goals around physical, psychosocial, therapeutic, financial, social, recreational and vocational needs. We were pleased to see that care plans took all of these into account, as well as the needs and strengths of the patient. The purpose of the admission was clear and we were pleased to find that discharge planning was referenced from the point of admission and again, recorded in the weekly MDT meetings.

The Commission's 2020 themed visit report on rehabilitation services highlighted the link between long-term mental health problems and an increase of physical health problems. We heard on the day of the visit that many of the patients in Cramond Ward have been in hospital for extended periods of time. Routine health screening that is available for those who live in,

and have access to these while in the community; for those patients who are in hospital for a long period of time, there should be equal access to these types of health interventions. We were pleased to find that there was a significant focus on physical health care for patients in Cramond Ward. There was evidence of physical health care needs being addressed and followed up appropriately. This was supported by the advanced medical practitioner who had a key role in overseeing the management of physical health co-morbidities for patients in the ward. We saw evidence of a culture that supported healthy lifestyles, particularly in relation to diet, exercise, and mental well-being. The majority of the patients we spoke to told us they had the opportunity to engage in regular exercise and had support with their diet and nutrition. For patients who required support with smoking, alcohol and drug addiction, we found evidence of this being offered via smoking cessation and referrals to NHS Lothian addiction services.

We found risk assessments to be of a high standard and included an associated safety plan. These included detailed pass documentation, recording the purpose of all time out of the ward and also included a failure-to-return plan.

The care plans were reviewed on a weekly basis and we found evidence of the patient's progress. In addition to weekly reviews, we also found that there were three monthly reviews through the Integrated Care Plan (ICP) process. We found comprehensive and detailed information recorded in the ICP. We were pleased to find that the ICP meeting was attended by the MDT and patient, and carer, where there was one involved; goals on mental health, risk, substance misuse, time off the ward and risk were reviewed regularly.

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

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a full-time consultant psychiatrist, trainee advanced medical practitioner, junior doctor, two occupational therapists (OT), three recreational workers, an art therapist and a music therapist. The psychologist had recently left post leaving a gap in the psychology input into the ward. This was a concern, given the importance of psychological intervention for patients in a rehabilitation service. We were advised by the CNM and SCN that recruitment for a new psychologist was being progressed and psychology cover for Cramond Ward was being arranged.

The MDT meet weekly in the ward. Patients and family were able to attend the ward round and we saw evidence of active patient participation in the MDT recording and heard about this from speaking with patients. The MDT ward round was recorded on TRAKCare. We found detailed recording of the MDT discussion, decisions and personalised care planning for the patients. We were pleased to see clear links between MDT discussion and the care plan outcomes. It was clear that everyone in the MDT was fully involved in the care of patients in Cramond Ward.

Use of mental health and incapacity legislation

On the day of our visit, twelve patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA). One patient was subject to Adults with Incapacity (Scotland) Act 2000 (AWIA) and one was subject to a Compulsion Order under section 57A of the Criminal Procedure (Scotland) Act 1995. We saw that detention certificates relating to the Mental Health Act and AWIA were stored electronically on TRAKCare.

On the day of the visit, we found that patients who were subject to AWIA legislation had the details of welfare proxies and the powers granted in the welfare and/or financial guardianship documented.

The patients we met with during our visit had a good understanding of their rights and detained status, where they were subject to detention under the Mental Health Act. All of the patients we met with had legal representation and advocacy support. We were pleased to see that information and support on rights was located in the main area of the ward.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file. We met with a named person on the day of the visit and they told us that they were supported in their role and felt involved in discussion and decision making.

Part 16 (s235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained patients who are either capable or incapable of consenting to specific treatments. Treatment must be authorised by an appropriate T2, T3 or T4 certificate to evidence capacity to consent. On reviewing the electronic and paper files we found that one patient did not have a valid T3 certificate authorising treatment. We raised this with the CNM and SCN on the day of the visit and requested an urgent review of the patient's consent to treatment that was undertaken. We also provided advice on informing the patient and named person of the period where unauthorised treatment had taken place and their rights in relation to this.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWIA 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 evidence of section 47 certificates for patients who required one. We noted that for one patient, there was no accompanying treatment plan; we raised this on the day of the visit with the SCN who agreed to alert the RMO for immediate follow up.

Recommendation 1:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid and record a clear plan of treatment.

Rights and restrictions

Patients in Cramond Ward are likely to suffer from either a psychotic illness or a mood related illness that is complicated by treatment resistance, substance misuse, physical health issues, and/or difficulty in engaging with health and social care services. The ward applies relational security to meet the needs of the patient group; this model of care supports the staff to have the required knowledge and understanding of a patient and of the environment, and ensures that the appropriate responses and care are provided.

Cramond Ward operates a locked door, commensurate with the level of risk identified with the patient group. There was an operational policy for the unit that explained the rationale for this.

S281 to 286 of the Mental Health Act provides 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 these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. One patient was specified on the day of the visit; we were able to locate the paperwork and reasoned opinion, authorising the restrictions.

When we are reviewing patient files we look for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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. On the day of the visit some of the patients we met with had an advance statement in their file. We also saw evidence of discussion between the patient and staff regarding progressing advance statements, particularly during ICP meetings. We were told by the SCN that for patients who are considering making an advanced statement, advocacy is contacted to support the patient in this process.

Advocacy services were available in the ward and provided by the local mental health advocacy service, Avocard. We were told that advocacy attend the ward on request and provide a good service to patients who wish to engage with them. We were pleased that all of the patients we met with on the day of the visit had advocacy support.

The Royal Edinburgh Hospital have a patient council group that offer collective advocacy. We were pleased to hear that some of the patients in Cramond Ward had involvement with the patient council and found it supported them to strengthen their voices on important in-patient care issues. We were impressed to hear that the patient council had recently delivered Human Rights based training to patients and staff, promoting rights based care to patients.

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

We heard and found evidence of a broad range of activities that were available for patients both in, and out with the ward. The activity and occupation in Cramond Ward is provided by OT's, recreational staff, music and art therapists. We were told that recreational staff met with

the patient group on a weekly basis during the coffee morning to discuss activities that patients would like to have planned for the week ahead. We heard there were regular group activities such as quizzes, karaoke evenings, pool competition and arts and crafts that patients could attend throughout the week.

There was an activities board in the communal dining with an area for patient suggestions and comments. The activities available include pet therapy, clay making, music jam, barge group, cycling group and pet therapy. The patients we met with spoke very positively and were complimentary about the activities offered in the ward and out in the community.

We met with the music therapist who had just started on the day of our visit. We were told that patients will be offered one-to-one and group music therapy. The aims of the music therapy included supporting patients manage strong emotions, making sense of their thoughts and feelings, relationship building and enjoy being creative.

We also saw and heard that patients were offered activities to enhance daily living skills, promote health and exercise, psychosocial education and support of vocational and educational activities. We found evidence of links with community based support. The files we reviewed included individualised activity care plans. We were pleased to see that the activity plans were regularly reviewed and had active input from the OT.

We were concerned to hear from patients and staff that due to staff shortages in other areas of NHS Lothian, planned individual and group activities could be cancelled at short notice. One patient told us that if the established staffing numbers were on duty in Cramond Ward, then staff would be moved to other wards. This has caused frustration as planned activities might not go ahead. Staff we spoke with told us that having to cancel planned activities has an impact on the therapeutic relationships they have with patients. Whilst we acknowledge the challenges of staff shortages, we were concerned that regularly moving staff can compromise the continuity of care and negatively impact on the patients' rehabilitation goals. We raised this with the SCN and CNM on the day of the visit who shared our concerns over the impact of moving staff from Cramond Ward. The CNM advised that these concerns have been raised with senior managers.

The physical environment

Cramond Ward is located on the first floor of the original part of the Royal Edinburgh Hospital. There is wheelchair access to the ward. The ward was newly refurbished prior to opening in 2020. The ward is a mixed-sex environment, with a mixture of single rooms and two bedded dormitories. The dormitories have en-suite facilities; patients in single rooms use shared bathrooms. We viewed a single room and a dormitory on the day and visit and found them to be clean and personalised.

Cramond Ward was well maintained with high standards of cleanliness. It is a spacious ward with two sitting areas in each section of the ward. The male sitting room had some homely furnishings, a table tennis table, which created a comfortable environment for the patients. The female sitting room was less homely and would benefit from more soft furnishings and art work to promote a less clinical environment.

There was a communal dining room in the middle of the ward. This is where patients and staff tend to gather to socialise and engage in activities. The dining area was attached to the pantry which was locked, the rooms are divided by a pull down shutter. On the day of the visit we noted that at times the shutter was half open with patients having to request hot drinks and food by either knocking the shutter or bending down to get staff attention. We were told by patients that there was restricted access to tea and coffee. We discussed this with the CNM and SCN who advised this was due to the identified risks of some patients when using hot water. We discussed that this was restrictive for the majority of patients on the ward who should have access to tea and coffee. The CNM and SCN agreed to review this practice and consider safer ways in which tea and coffee could be offered to all patients.

There was a spacious kitchen on the ground floor of the hospital that patients used to cook. The kitchen had adjustable appliances for patients with mobility issues. The patient could opt into the ward cooking programme as part of their care plan. The cooking programme supports patients to purchase and cook their own food and they were provided with a food budget.

The ward had a large laundry room that patients used to wash, dry and iron their clothes.

There was a shared garden area on the ground floor that Cramond patients used. We viewed the garden on the day of the visit. The garden was spacious and had seating areas for patients, however it would have benefitted from additional plants and greenery to promote a more therapeutic space.

There was evidence of discarded cigarettes around the area and we saw patients smoking in the garden on the day of the visit. We heard from SCN that due to restrictions during Covid-19, NHS Lothian have sought advice from public health to permit smoking in the garden areas; this is to prevent patients smoking in the ward environment due to the associated risks. We heard that plans were in place to support a no-smoking environment. A smoking cessation worker had been employed alongside a senior health promotion worker. They planned to review all of NHS Lothian's smoking policies and support in their implementation.

Any other comments

We were encouraged to hear about the commitment to development of Cramond Ward and the other rehabilitation services in the Royal Edinburgh Hospital. We were impressed to hear from the CNM that every service involved in rehabilitation care and treatment met on a monthly basis to discuss service gaps, highlight areas of improvement which were required and assess what was working well. The CNM and SCN had been making links with rehabilitation services in other health boards to discuss new practice ideas, view different environments and consider any new care and treatment that would be beneficial to the patient experience in Cramond Ward.

Summary of recommendations

Recommendation 1:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid and record a clear plan of treatment.

Service response to recommendations

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

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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Mental Welfare Commission 2023