Mental Welfare Commission for Scotland

Report on unannounced visit to: Royal Edinburgh Hospital, Comiston Ward, Morningside Terrace, Edinburgh, EH10 5HF.

Date of visit: 8 November 2016

Where we visited

Comiston is a 13 bedded mental health rehabilitation ward for men and women over 65 years of age. Most individuals admitted to Comiston are transferred from Eden Ward, which is the functional assessment unit for older people at the Royal Edinburgh Hospital. In Comiston, ongoing work is undertaken with people to enable them to return home or move on to other suitable accommodation.

We last visited this service on 18 June 2015 and recommended that the service reviewed clinical psychology provision; care planning procedures; documentation of the weekly ward round; and addressed some environmental issues.

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 eight patients and one relative.

We spoke with the senior charge nurse and other nursing staff on the ward. We met one patient with their advocate.

Commission visitors

Dr Mike Warwick, Medical Officer

Moira Healy, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Patients seemed comfortable in the ward and in the company of staff. The ward atmosphere was calm and relaxed. Staff were very knowledgeable about people as individuals when we discussed patients with them.

Patients we met made very positive comments about staff and the care and support they receive from them. They knew who their named nurses were and said they have one to one meetings with them. The relative we met said she finds staff kind and supportive, they keep her well informed, and she thinks the care they provide is excellent.

It was good to hear from the senior charge nurse that the nursing team is fully staffed and that the team has been able to undertake more development work recently.

An occupational therapist (OT) is a core member of the ward team four days per week. There was a gap in OT provision at the time of our visit. The previous OT had left four weeks earlier and the new post holder was due to commence work imminently.

The ward therapeutic group programme includes relaxation, anxiety management and recovery groups.

Psychological therapies

At the time of our last visit, staff were delivering solution focussed brief therapy. On this visit the senior charge nurse told us that staff are still undertaking this with patients informally, but there is no solution focussed therapy group now. She said it had been hoped to train more staff in this approach but the trainer has retired.

At the time of our last visit, dedicated clinical psychology provision had reduced. A clinical psychologist was attending the ward round and could see up to two patients individually. We recommended that there should be a review of clinical psychology provision. We did not receive an update from the service.

We were disappointed on this visit to hear that a clinical psychologist no longer attends the ward round and there is no dedicated clinical psychology input. A trainee clinical psychologist may be attached to the ward. This is variable. A trainee was seeing two patients at the time of this visit but was about to move on. The senior charge nurse said a meeting to discuss clinical psychology provision had been held two months previously but they had not received feedback from this.

Recommendation 1

Managers should review the provision of psychological therapies in Comiston. This should include consideration of the need for dedicated clinical psychology provision, both for direct work with individuals and for supervision and support of nursing staff in the delivery of psychological therapies.

Multidisciplinary notes were easy to navigate and contained good, detailed accounts of care and treatment provided. It was clear from note entries that patients were having one to one conversations with nursing staff. We advised that it would be helpful if staff could highlight these.

Nursing care planning

Nursing care plans for mental health needs had good person centred content in the sections on identified need and goals. The interventions section was usually more generic. Review and evaluation entries often commented more on symptomatology than specific aspects of the care plan or development of this.

Some of these care plans covered a number of areas that we thought could helpfully be broken down into a number of smaller, more focussed care plans.

Recommendation 2

Managers should further develop nursing care planning procedures to include more individualised interventions and evaluation of each intervention when the care plan is reviewed.

Documentation of the weekly ward round

Nursing staff create a useful summary for the weekly ward round and medical staff make a note entry from the meeting. This does not always include an attendance list. We made a recommendation about improving ward round documentation following our last visit. A new recording sheet was introduced but not continued. Multidisciplinary team meeting documentation developed elsewhere in the hospital is soon to be introduced in Comiston (i.e. the documentation known locally as "SCAMPER", as sections within the document form this acronym). We look forward to seeing this in use on future visits to Comiston.

Use of mental health and incapacity legislation

Adults with Incapacity (Scotland) Act 2000 s47 certificates

We saw a s47 certificate that contained a general entry that did not cover any specific medical conditions. 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'). 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

The Commission has published good practice guidance on the use of s47 in general hospitals. This contains advice about how to correctly authorise medical treatment:

http://www.mwcscot.org.uk/media/340709/awi_in_general_hospitals_final_2.pdf

We recommended following a visit to another ward in the service that managers should ensure that medical staff are trained in correct completion of s47 certificates and treatment plans. We received an update just prior to this visit that this was being addressed by the clinical nurse manager and clinical director. It should be ensured that this includes all medical staff in the older people's service.

Adults with Incapacity (Scotland) Act 2000 – welfare proxies

One patient was on welfare guardianship. There was no reference to this in the admission assessment and no copy of the powers in the notes (however, they had only recently been admitted, and nursing staff were familiar with the fact they have a welfare guardian). Another patient had a relative who said they were their power of attorney but no documentation to support this had been obtained for the notes.

There was a section on the front sheet of the notes for recording whether or not the patient has a welfare guardian or welfare power of attorney that we considered to be confusing. We recommended following a visit to another ward in the service that managers should review this. We received an update just prior to this visit that this is being done.

Recommendation 3

Staff should ensure that, if there is a welfare proxy, they obtain a copy of the guardianship order or power of attorney and file this in the patient's notes.

Activity and occupation

Nursing staff, the OT (when in post) and the OT assistant provide social and therapeutic activities and support people on an individual basis to access the community and their homes. Ward group activities include exercises; walking group; music; reminiscence; baking; and other creative activities.

Patients can attend activities at the Hive (activities centre within the hospital run by the Scottish Association for Mental Health).

We have commented above that some patients had mental health care plans that covered a number of areas. Some people did not have a separate activities care plan.

Staff prepare an individual activity timetable with each patient weekly, but we generally could not find a clear record of whether they engaged in these activities. One patient had ward groups on their weekly timetable that they did not attend. We suggested to the senior charge nurse that it would be helpful to keep a record on the timetable of whether the individual participated in a planned activity, if not why not, and review this.

We appreciate that some patients are reluctant to engage in activities. We consider that improving activities care planning, recording of participation and evaluation would help to maximise patients' engagement in activities.

Recommendation 4

Nursing staff should prepare a separate activities care plan for all patients. A record should be kept of the individual's participation in planned activities and this should be regularly reviewed and evaluated.

The physical environment

Comiston opened around seven years ago. It has the advantage of being near the hospital gate exiting to Morningside. The ward was refurbished, but was not built for purpose. The unit is in good decorative order, and efforts have been made to make the most of the available space. Three of the bedrooms are single rooms, the rest are shared.

There is a central lounge area in the middle of the ward, and a bright activity room with a TV. The garden is a slabbed courtyard with garden furniture and trough beds, which is directly accessible from the ward.

We raised some environmental issues following our last visit. We were particularly concerned about a dormitory room that we thought was too small for five women. The service made the decision to reduce the number of beds in that room to four, and the maximum number of patients in the ward from 14 to 13. This has significantly improved individual bed space for patients in that room.

In our last visit report we raised issues with lack of privacy for women to be able to conduct personal care at the sinks in the five-bedded (now four-bedded) dormitory, and the toilet area adjacent to the shower room . We received an update from the service stating that privacy screens would be placed around those sinks. This has not been done. We appreciate that male staff no longer use the toilet mentioned, which has improved things somewhat. However, whether to screen that sink should be reviewed, and we consider that screening the sink in the dormitory would be beneficial and should be done.

On this visit one patient raised with us that they find sitting at the payphone uncomfortable. Due to the phone being mounted quite high on the wall, and the length of the cord, it is necessary to sit right underneath the phone to use it and it is not possible to sit at the desk in the room. We recommend that this is reviewed to see if it can be made more comfortable.

Recommendation 5

Managers should make arrangements for the planned screen around the sink in the female dormitory to be installed, and review whether there remains a need to screen the sink in the female toilet.

Managers should review whether the payphone or its location can be modified to make it more comfortable to use.

Summary of recommendations

Recommendation 1

Managers should review the provision of psychological therapies in Comiston. This should include consideration of the need for dedicated clinical psychology provision, both for direct work with individuals and for supervision and support of nursing staff in the delivery of psychological therapies.

Recommendation 2

Managers should further develop nursing care planning procedures to include more individualised interventions and evaluation of each intervention when the care plan is reviewed.

Recommendation 3

Staff should ensure that, if there is a welfare proxy, they obtain a copy of the guardianship order or power of attorney and file this in the patient's notes.

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Recommendation 5

Managers should make arrangements for the planned screen around the sink in the female dormitory to be installed, and review whether there remains a need to screen the sink in the female toilet.

Managers should review whether the payphone or its' location can be modified to make it more comfortable to use.

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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