mentalwelfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Cedar and Hawthorn Wards, Orchard Clinic, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 28 August 2018

Where we visited

We last visited the rehabilitation wards at the Orchard Clinic on 16 June 2016. We made no recommendations on this visit.

The Orchard Clinic is a 40-bedded, medium-secure forensic unit on the Royal Edinburgh Hospital campus. There are two forensic rehabilitation wards within the clinic.

Cedar is a 14-bed rehabilitation ward for men. Hawthorn is a mixed-sex rehabilitation ward, with 13 beds. On the day of this visit, there were 14 patients on Cedar ward and 11 patients on Hawthorn, four of whom were female.

On the day of this visit we wanted to meet with patients and carers and follow up on recent environmental issues at the clinic.

Who we met with

We met with and/or reviewed the care and treatment of nine patients. No carers/relatives/friends asked to meet with us on the day.

We spoke with the service manager, lead consultant, senior nurses, and staff from both wards. Following the visit we also spoke with the advocacy service, Patients Council and the Carers Council.

Commission visitors

Juliet Brock, Medical Officer

Claire Lamza, Nursing Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Patients we met made positive comments about staff and the care and support they receive from them.

Individuals on Hawthorn Ward in particular spoke enthusiastically of being involved in their care planning and in setting their rehabilitation goals. They told us that staff focused on their individual strengths and worked alongside them to help achieve their goals.

As on previous visits, interactions we observed staff having with patients were caring and respectful. When we spoke to staff about patients it was clear that they know them well and deliver person-centred care.

Two peer-support workers continue to work with the team, assisting patients in completing their Wellness Recovery Action Plans (WRAP). We heard that their support and perspective was valued by both patients and staff.

The computerised notes system were now on TRAK. Patient records were held either on TRAK or in paper files, depending on document type. TRAK does not currently support care planning. Daily notes on patient care, individual reviews, and team meeting notes were recorded on TRAK by members of the multidisciplinary team. Care plans, legal, consent, and other documents were held in the paper notes.

There were difficulties for us to access TRAK securely on the day of the visit. Staff provided copies of patient documentation that we asked to review. The lead clinician advised he would liaise with IT services to enable Commission visitors to fully access patient files on future visits.

The care plans used set out a high number of care goals (12). We found these varied in completion, quality and individualised content. We heard that care planning continues to be a work in progress with aims of making it more person centred, and that co-ordinators on each ward are reviewing care plans as part of ongoing audit processes. We suggested that managers closely review the audit process that is taking place. We will continue to review this on future visits.

Copies of care programme approach (CPA) documentation we reviewed were detailed and comprehensive. We saw good evidence of weekly risk monitoring and supervision (WRMS) documentation. There was a strong multidisciplinary focus within the clinic. There were occupational therapists attached to every consultant team in addition to input from art therapy, music therapy, psychology, dietetics, and pharmacy. Physiotherapy could be accessed by referral. Nursing staff were encouraged to develop additional therapeutic skills and there was a nurse therapy team within the clinic offering a range of psychological approaches, supported and supervised by psychology.

There continued to be good links with advocacy services. Individual independent patient advocacy was provided for patients by Advocard. Orchard Clinic collective advocacy meetings were held with the Royal Edinburgh Hospital Patients Council. We heard that there was a tendency for there to be more engagement from patients on Cedar than Hawthorn Ward and that feedback was generally very positive, with staff described as being compassionate and having a strong recovery focus.

The Edinburgh Carers Council had regular contact with the clinic and told us that staff engage well with families and were responsive when any issues arise. They told us that the carers planning group run by the Orchard Clinic has also been well supported. The group has representation from the mental health officer (MHO) team, nurses, consultants, and the Carers Council. It had been running for four to five years and met every six weeks. The group had successfully drafted a carers strategy for the clinic, accessed travel expenses for families from some health board areas and provided representation at the National Forensic Carers Conference.

Use of mental health and incapacity legislation

All patients were detained under the Criminal Procedures Act or the Mental Health (Care and Treatment) (Scotland) Act 2003.

The patients whose prescriptions we reviewed had a consent to treatment form (T2) or certificate authorising treatment form (T3) in place where this was required.

Some patients prescribed antipsychotic medication were at times receiving daily doses above those recommended in the British national formulary (BNF). Where this was the case, appropriate high dose monitoring was in place. In a small number of cases this monitoring was carried out on an annual basis, less frequently than would normally be expected. We followed this up with the consultant psychiatrist and there were appropriate reasons why this was happening in individual cases.

Rights and restrictions

The risk monitoring and supervision documentation, completed weekly, included sections to review current restrictions. Patients' individual pass plans were reviewed in accordance with risk assessments.

One patient raised a question with us about an advance statement override relating to their medication. We reviewed this with them on the day. We were told that a psychiatry higher trainee is undertaking a project on the use of advance statements. We look forward to hearing the outcome of this on our next visit.

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/media/369925/human_rights_in_mental_health_services.pdf

Activity and occupation

A strong emphasis on the provision of individual and group therapeutic activities continued within the Orchard Clinic.

Occupational therapists provided a range of groups within the clinic and additional resources could be accessed at the Hive, a provision for patients across the hospital site. The Hive offered groups ranging from computer classes to yoga, to therapeutic groups such as 'Hearing Voices'.

Patients told us they enjoyed accessing activities both within the clinic and at the Hive, in addition to the Cyrenians gardening project on site.

On Cedar Ward, patients were very positive about their individual activity programmes and the wide range of activities that were tailored to their personal interests. The activity nurse was especially praised by patients for his support and creativity in developing these individual programmes. The programmes included both hospital and community-based activities, sometimes offering a volunteering, educational, or vocational focus. Examples included hillwalking, cycling, kayaking, birdwatching, music clubs, choir, community gardening, and workshop projects. We were told that ward staff also organise activities during the weekend. These included exercise groups (e.g circuit groups, walking), mindfulness and social activities. In addition, patients told us that the staff organised outings when possible and for example had taken some individuals to events during the Edinburgh Festival, which they had very much enjoyed. We heard from patients that for those individuals unable to have time out of the ward, staff "go out of their way" to offer ward-based activities such as cooking and games groups.

No activity co-ordinator was currently appointed on Hawthorn Ward. Our impression on this visit was of a difference in the activity programme and rehabilitation focus between the two wards. We explored this with staff on the day. It was suggested that the patient groups are slightly different, with some patients on Hawthorn perhaps having more complex, long-term needs. Unfortunately we were unable to gather feedback from many patients on the ward on this particular visit.

Recommendation 1:

Managers should review the needs of the patients on Hawthorn Ward and consider whether the appointment of an activity co-ordinator would be of benefit.

The physical environment

We were aware of persistent problems with the heating across the clinic. This led to a serious incident earlier this year. We were pleased to have confirmation from managers that the necessary repairs had been completed and the problem resolved. The heating across the clinic will continue to be monitored by managers.

We were informed that an incident had occurred a few weeks prior to this visit requiring the clinic's security system to be urgently upgraded. We were advised that this work had been completed and there were no ongoing safety issues.

The décor and general environment on both wards was of a reasonable standard. We questioned whether the environment on Hawthorn could be more gender-sensitive, with female-only areas being defined.

There have been long-term plans to establish a female-only ward at the Orchard Clinic, however senior staff advised on this visit that there was no funding to progress the plans in the foreseeable future.

Recommendation 2:

Managers should review the needs of the female patient group on Hawthorn Ward and address any requirements for additional female-designated areas on the ward.

Summary of recommendations

1. Managers should review the needs of the patients on Hawthorn Ward and consider whether the appointment of an activity co-ordinator would be of benefit.

2. Managers should review the needs of the female patient group on Hawthorn Ward and address any requirements for additional female-designated areas on the ward.

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.

Alison Thomson, 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 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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