Mental Welfare Commission for Scotland

Report on announced visit to: Craiglockhart Ward, Royal Edinburgh Hospital, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 29 October 2018

Where we visited

Craiglockhart is a 16-bedded adult acute female admission ward with a catchment area that includes the north west and north east areas of NHS Lothian. We last visited this service in November 2017, along with the other three acute admission wards for the city of Edinburgh, and made recommendations relating to bed management, care planning, consent to treatment, restrictions, and the physical environment.

On the day of this visit we wanted to follow up on the previous recommendations and also look at the experience of patients receiving care in Craiglockhart Ward.

Who we met with

We met with and/or reviewed the care and treatment of six patients and met with two relatives.

We spoke with members of the nursing team, the senior charge nurse, the recreation nurse, the psychologist, and two consultant psychiatrists.

Commission visitors

Claire Lamza, Nursing Officer

Dougie Seath, Nursing Officer

Cindy Mackie, Board Member

What people told us and what we found

Care, treatment, support and participation

Those that we spoke to told us that staff were excellent, were available to help and to support them. We were told that they “can’t be praised highly enough”, and we were able to observe how supportive staff were. As we were shown round the unit, patients approached us and told us about activities that were on offer to them, how they could easily find staff when they needed them, and how their issues were resolved with the assistance of staff.

We were aware that for some patients and their relatives, there were concerns related to their care and treatment. We found that members of the clinical team were available to meet with and discuss these concerns.

There are some challenges in managing the needs of the patient group, and the teamwork and collaborative working in the ward was evident. We found that there were opportunities for newly-qualified staff to take on specific roles and projects. We found new initiatives being rolled out, and there was support for staff in terms of their practice and in the development of their knowledge.

On our last visit, we identified that a systematic process to review care plans should be developed to ensure improvements in quality and completion. While we found that action has been taken with this recommendation, there is still further work needed.

Craiglockhart currently has both electronic and paper care plans, and to fully review each patient access to both is required. In the electronic version (TrakCare), the shift-by-shift progress notes the outcomes of the multidisciplinary review meeting, using SCAMPER, and one-to-one nurse sessions are all documented.

Legal documentation in relation to the Mental Health (Care and Treatment Act) (Scotland) 2003 (MHA) is also stored on TrakCare. However, the care plan, patient's care goals, the risk assessment, the pass plan and other documents are paper-based.

We were pleased to find evidence of the use of the person-centred audit tool (PCAT) and monthly evaluations of care plans. We were advised that this system is in the process of moving to an electronic reporting process so that closer monitoring and effective change could take place. However, we found variations in the quality of the completion of 'my care plan', the goal and intervention document used by adult acute inpatient services at the Royal Edinburgh Hospital (REH). Some patients had detailed, personalised care plans that they had participated in and signed while others had a single goal that was not person centred. We also found that the paper care plans had historical documents that were no longer required. We found that some key information was missing from assessments, specifically where there were risks to the patient.

Recommendation 1:

Managers should ensure that all aspects of care plans reflect the needs of patients, are individualised, and provide the updated information.

Use of mental health and incapacity legislation

In the care plans we reviewed we found the relevant paperwork relating to the MHA, along with reports from Mental Health Tribunal for Scotland (MHTS) hearings. We also found copies of advance statements where it was indicated that the patient had made one, and clear recordings of the named person details where one had been identified.

We were pleased to find that all forms for consent to treatment under the MHA (T2) and forms authorising treatment (T3) were available on both TrakCare and with the medication prescription sheet. All of the forms that we reviewed were up to date and covered the prescribed medication. At the visit, we found a prescribing issue where medication was prescribed orally, and also intramuscular (IM), for a patient who was in hospital informally. We raised this with the medical staff on the day.

A previous recommendation was to evaluate the process that is put in place when a patient is made a specified person. Sections 281 to 286 of the MHA provide 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 MHA, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions is regularly reviewed.

From the care plans we reviewed, we found the restriction had been legally authorised. However, evidence of the reasoned opinion and the appeal process that should have been provided for the patient was not documented clearly in the patient's care plan.

Our specified persons good practice guidance is available on our website:

http://www.mwcscot.org.uk/media/216057/specified_persons_guidance_2015.pdf

Recommendation 2:

Managers should ensure specified persons procedures are followed.

Rights and restrictions

Access in and out of the ward is via a locked door, although there was always a member of staff nearby who would assist patients and visitors who asked to enter or leave the ward. There was also a courtyard garden directly off the main day areas so that patients could have access to an outdoor space.

We found updated pass plans in all of the care plans that we reviewed, which clearly indicated the level of observation, the allocated time off ward, whether it was escorted or unescorted, and the areas they were able to access. We were pleased to see that for patients who were on more restricted levels of observation, positive risk-taking strategies were in place. Equally there was clear information to make staff aware of levels of observation through the care plans and safety briefings.

We noted that for those patients that requested it, there was involvement with advocacy and legal representation. We found advance statements in care plans for patients that had one, and there was a section in patients' care plans that documented if they had been made aware about their rights. From those that we reviewed, not all were completed.

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/rights-in-mind/

Recommendation 3:

Managers should ensure that when patients are made aware of their rights, this is clearly documented.

Activity and occupation

We found evidence, documented in patients care goals and progress notes, that indicated the frequency and outcomes of activities. We noted opportunities for patients to attend the Hive, an activity centre based in the grounds of the Royal Edinburgh Hospital (REH). For those not able to leave the ward, there were a range of activities provided by the occupational therapy service and the recreation nurse. The range was extensive and included building IT skills, baking, art, yoga, cooking sessions and facilitated outings.

Patients have access to a limited number of psychology sessions. However we were made aware that additional resources will be put in place in the near future.

The physical environment

The ward is modern and fresh, with spacious day areas and an accessible courtyard garden. There have been developments to brighten the main corridors with art work and one wall had been dedicated for a mural of a discharge tree. There were patient information boards and flyers advertising all of the activities and events that were available for patients.

We were impressed with the development of a room that was previously designated as an alternative quiet space. It now offers different therapeutic groups including low-intensity psychological group-based interventions, art and crafts, and social groups. However, we had previously noted the limited options in terms of interview/meeting areas and, while the change to the quiet room is to be welcomed, it further impacts on the lack of alternative spaces for patients and visitors. The response from our previous recommendation stated that “consideration of any variations and associated work/costs would be proposed to senior managers”. Due to our ongoing concern, we would expect that further progress be made with the associated work to increase interview/meeting rooms.

We found that all areas were well maintained and clean. Patients have their own rooms with en-suite facilities and are able to personalise these. There is also an additional bathroom for patients who prefer this option.

Any other comments

We were made aware of the development of Safe Wards, which is to be rolled out across adult acute inpatient wards at the REH. The discharge tree mural that was noted above is one of three strands that is being taken forward in Craiglockhart Ward. On entering the ward, we were pleased to see A4 documents displayed that introduced and gave details about staff members. We thought this was helpful for patients and visitors in getting to know the team. The second strand is soothing/calming boxes, and again there was evidence of their effectiveness when we spoke to patients who told us that they enjoyed making their own personalised box.

The third strand relates to mutual responsibility and has started, in the first instance, with staff development opportunities. Reflective practice sessions with psychology, tailored training with the clinical nurse specialist for self-harm, and opportunities to lead on projects such as safe wards and the ward co-ordinators role are helpful for the newly qualified practitioners in the ward.

Summary of recommendations

1. Managers should ensure that all aspects of care plans reflect the needs of patients, are individualised, and provide the updated information.

2. Managers should ensure specified persons procedures are followed.

3. Managers should ensure that when patients are made aware of their rights, this is clearly documented.

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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