Mental Welfare Commission for Scotland

Report on announced visit to: The William Fraser Centre, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 28 November 2018

Where we visited

The William Fraser Centre is part of NHS Lothian's learning disability service, located in the grounds of the Royal Edinburgh Hospital. The centre is divided into three areas with a total of 12 beds. Strathaird is a five-bedded, male-only unit. Culzean is a three-bedded female unit, and Rannochmor has four beds, again for female patients.

The centre acts as the main admission service for all patients with learning disabilities across NHS Lothian. It admits patients with a mild to moderate learning disability, who may have additional difficulties such as mental ill health, forensic issues, autism, and/or challenging behaviour.

We last visited Rannochmor on 6 August 2015 as part of a themed visit for learning disability inpatient units. Areas for improvement included summative reviews, individualised risk management plans, physical healthcare monitoring, and repairs to the environment. Since this visit the centre has had a period of closure for building renovations, and the visit scheduled for 2017 was postponed to accommodate this.

On the day of this visit we wanted to follow up on those areas that were identified for improvement in 2015, and also look at the impact of the environmental changes in meeting the patient's' needs.

Who we met with

We met with and reviewed the care and treatment of six patients. We were able to speak to one relative prior to the visit.

We spoke with the senior charge nurse (SCN), the clinical nurse manager (CNM), and one of the responsible medical officers (RMO), as well as meeting with advocacy workers for the patients we met with.

Commission visitors

Claire Lamza, Nursing Officer

Juliet Brock, Medical Officer

What people told us and what we found

Care, treatment, support and participation

From the patients that we were able to speak with, and from the carer who had contacted us prior to the visit, we were provided with a range of information that expressed their views of care and treatment. Our impression was that, while there were specific issues relating to individuals, in general everyone we spoke to described different situations where staff had been supportive and effective in meeting patients' needs. We heard that staff are helpful when patients want to talk about their problems, that they are supportive and efficient when issues need to be addressed, and that they

offer opportunities to resolve difficulties with one-to-one contact, both for patients and carers.

There is a full multi-professional clinical team that provides input to the centre. This includes two consultant psychiatrists: one that covers learning disabilities and mental health, and one for patients with forensic backgrounds. There is an ST5 doctor, who has responsibility for the physical health care of the patients, and junior medical staff. Pharmacy, psychology, occupational therapy, art, music, and speech and language therapists, as well as nursing staff and recreational assistants, cover the care and treatment for both groups of patients. We were impressed with the team approach to care and with multidisciplinary working.

On reviewing the care files, we found these to be of a good standard. All of the files we reviewed were well organised, and included detailed paperwork in relation to treatment plans, risk assessments and management plans, and multidisciplinary reviews.

We found the document that provided key information and a history of each patient gave a comprehensive overview of the individual. The weekly multidisciplinary team (MDT) summary/outcomes document also helped in understanding how various aspects of the patient's care and treatment had progressed over time. We were able to review behaviours and activities across mental, physical, social, and legal domains. The document also gave details around the discussion from the MDT, and actions that were taken.

We found good monitoring of physical healthcare, with the use of a locally developed document that used pictures and images for "my important health information". Checks and interventions were routinely carried out by medical and nursing staff. In addition to the health care document developed by the service, there was another for care programme approach (CPA) reviews and one for patient consultation prior to meetings. This supported patient involvement by the patient identifying what were the most important things that they wanted discussed and, if advocacy was required, any barriers and what supports would be helpful. In general, we found the care files to be person centred and tailored to each individual's needs.

Treatment plans were reviewed in relation to the treatment goals and, where possible, patients had been actively involved in their care plans. However, in some files we found that there were a substantial number of goals covering a period of more than five years. We think that having this many goals may impact on the review process, and consideration could be given to develop current and succinct goals

Recommendation 1:

Managers should review the process for developing treatment goals.

Use of mental health and incapacity legislation

Patients in the William Fraser Centre are subject to a range of mental health and incapacity legislation, either compulsory treatment orders or welfare guardianship orders - and in some instances both. In the files we reviewed, we found all of the necessary paperwork and documentation relating to the Mental Health Act (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) and Adults with Incapacity (Scotland) Act 2000.

Consent to treatment certificates (T2) and certificates authorising treatment (T3) were all accurate and in date. On the day of the visit, we noted that for some patients there were additional medications authorised on the T3 forms that were not being given, but were advised that this was due to recent changes with prescribed medication.

We found that section 47 certificates, which authorise medical treatment for people who are unable to give consent, were of a good standard and personalised to the patient. There was information about conditions which the treatment was prescribed for, and we found detailed treatment plans accompanying the certificate.

For those patients where a guardian or proxy had been appointed, we found copies of orders granted in the care files. We feel that this is helpful, as it ensures that nursing and medical staff are clear about the powers the welfare proxy has to make decisions.

Rights and restrictions

The William Fraser Centre has a locked main entrance and exit door, and access to each individual unit is locked. There is an operational policy for the unit that explains the rationale for this.

The centre also has two seclusion rooms, one for men and one for women. Where seclusion was used, we found it documented clearly through the care plan and discussed at the MDT. Of the files we reviewed, all had detailed risk assessment and management plans, as well as a useful checklist. For those where seclusion was used, this was identified in their treatment plans.

A number of patients were specified persons in relation to section 281-286 of the Mental Health Act, which can allow certain restrictions to be placed on patients. The Commission expects restrictions to be authorised, and the need for restrictions to be regularly reviewed. We were pleased to see that the forms were detailed in terms of the restrictions that applied, with a reasoned opinion noted in the care file. Where a patient was restricted, this was highlighted and reviewed as part of the MDT weekly meeting and recorded on the summary/outcome document.

There is access to a dedicated advocacy service for patients in the centre. At the visit, some patients who met with us had an advocate present.

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/

Activity and occupation

We were pleased to find activity timetables in patients' care files and, for some patients, another copy in their room. There was also an activity board with details of different activities available in the unit, and across the hospital site, visible in the main area of the ward.

A broad range of activities was available which included art therapy, music therapy, supported meal making, visits to the Hive (an on-site recreational centre based in hospital grounds), outings for meals, shopping trips, local community visits, and volunteer work. The centre has input from the two recreation nurses, as well as from staff from Newington Day Centre, who also support patients accessing community activities.

There was clear evidence of one-to-one meetings and activities undertaken with the recreation nurses and the patients' key workers, which had been documented in the care files. We were told that there are plans to gradually develop nurse-led low intensity psychological sessions, and that staff in the centre have recently received training in working with personality disorder. We consider it to be good practice for staff to have opportunities that promote development, and the staff in the William Fraser Centre have access to formal supervision using mentalisation-based therapy (MBT). This is useful as the roll out of psychological approaches and interventions are made available for patients.

The physical environment

The centre has recently undergone some renovation work, and the main day areas are spacious with comfortable furniture, and are all freshly decorated. There have been efforts made to provide a privacy screen on the bedroom doors, and patients' rooms are personalised and homely where possible. There are no en-suite facilities in the centre, although bath, shower, and toilet facilities are adequate.

There is access to outside space for each of the three units, and plans are in place to develop the large garden area for Strathaird so that patients can access and enjoy the area. There were some environmental issues, such as the temperature in one room and the lack of pictures in the main corridors. These were discussed on the day of the visit. There is a lack of meeting rooms, and some areas have been designed to be multi-functional. While future plans include a new build, this is some years away. The current system of booking the available meeting space should be as flexible as possible to meet visitors' needs.

Summary of recommendations

1. Managers should review the process for developing treatment goals.

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.

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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