

**Mental Welfare Commission for Scotland**

**Report on announced visit to:** Hermitage Ward, the Royal Edinburgh Hospital, Edinburgh EH10 5HF

**Date of visit:** 13 February 2018

## **Where we visited**

Hermitage Ward is the adult acute admission ward for patients who reside in East and Midlothian areas of NHS Lothian. The ward has 16 beds, for both male and female patients.

The nursing team includes a senior charge nurse (SCN), supported by deputy charge nurses (DCN) and a team of registered nurses and nursing assistants. The nursing staff establishment for the unit routinely has five staff per shift during the day and three staff at night.

There is a consultant psychiatrist, with junior doctor support, although consultants who work in the other adult acute admission wards have input into the ward. There is dedicated time from clinical psychology, and referrals for occupational therapy are made on an individual basis. Until recently, the ward had access to music therapy, but this will not be available again until later in 2018.

This is the first time the Mental Welfare Commission (the Commission) has visited the new ward which opened in 2017.

This was an announced visit, the last local visit on 5 April 2016, was unannounced, although all admission wards were visited as part of the Commission's adult acute themed visit report in 2016/2017.

Recommendations from the last visit were for the ward manager to conduct an audit of all care plans and reviews so that the progress could be consolidated and sustained. The ward manager was also, in consultation with patients, to audit the provision of activities on the ward and ensure that staffing levels reflected the needs of the particular group of patients.

## **Who we met with**

On the day of our visit, we met with 10 patients and reviewed their care plans. We also met four relatives and had contact with one further relative after the visit.

We met with the SCN, and throughout the day we had an opportunity to talk to other members of the nursing team, and the ward clerk.

## **Commission visitors**

Claire Lamza, Nursing Officer (visit coordinator)

Tony Jevon, Social Work Officer

## **What people told us and what we found?**

### **Care, treatment, support and participation**

The feedback we received about the care and treatment varied. Some patients and carers were very positive about their in-patient stay, advising us that staff were helpful, accessible and 'there if you needed to chat'. Some of those we spoke to told us that they thought there had been significant improvements in the leadership in the ward and in the attitudes of the nursing team. Others advised us that, at times, the care they personally wanted, or the care that their carers had requested, was not always put in place; we were made aware of some issues where the views held by patients and their carers differed from that of the members of the multidisciplinary team, to the extent that it was considered to be having an impact on the patient's experience of their care. We discussed this with the SCN on the day of the visit.

When we reviewed the care plans, we found further variation in terms of the goals that were recorded and the evaluation of these. We found different templates being used to identify the patients care goals. Some care plans had a number of goals that adequately reflected their needs according to their length of stay. In others, where we would have expected more goals to have been defined as part of the care and treatment, there was only one goal.

In addition to this, the document that is used for the weekly review, SCAMPER, again varied in terms of completion. When fully completed, these provided clear evidence of weekly progress for the patient and an evaluation of the patient's goals. In other notes we reviewed, the SCAMPER was incomplete.

We were told about, and found evidence in the care plans about, the range of treatments provided by different disciplines. Patients have been able to access psychology and dietetics, as well as specialist services such as the clinical nurse specialist for self-harm and external community-based care providers, Edge Autism.

We also found that in some care plans, there was active participation in the goals that were set, in the evaluation of the goals and with the countersigning of the care plan. This was not applicable to all of the care plans we reviewed. Having discussed this with the SCN, we were made aware that there is ongoing work in relation to care planning. However, we note that this was a recommendation in the last visit report and the inconsistent approach to person-centred, evaluated and reasonable care goals remains an issue.

### **Recommendation 1:**

Managers should review and agree an accepted template, standards for care plan documentation and evaluation for the ward.

At the time of our visit, five of the 16 patients who were in the ward were detained under formal legislation. For those who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA), we found all of the paperwork associated with the detentions kept on the electronic system. We also found the consent to treatment form (T2) and the forms authorising treatment (T3) along with the medication recording charts. We reviewed these and found that all medications were covered by the forms.

We were aware that one patient was under a local authority welfare guardianship order, however, there was no record of this on the electronic patient record, Trakcare. We advised the SCN of this on the day but found that Trakcare does not have a domain where clinical staff can add this information to the system.

### **Recommendation 2:**

Managers should update the electronic patient record system, Trakcare, so that information relating to the Adults with Incapacity (Scotland) Act 2000, can be added.

### **Rights and Restrictions**

We were pleased to see that there was clear evidence of patients being informed about their rights, and of staff identifying whether the patients had understood these rights and asking patients about their advance statements. We found that the recording of this through the care plans varied; it was documented in some of those that we reviewed, but not in others. We would advise that this is also addressed through recommendation 1.

There were two patients who had been designated as specified persons. S281 to 286 of the MHA provide a framework within 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. We found the relevant paperwork on Trakcare and both patients had access to advocacy and legal advice. We found evidence of the reasoned opinion in the care plan and that the patients had been informed about their right of appeal.

There were no patients on constant observation on the day of our visit. We found pass plans that were up to date and easy to follow, and there were risk assessments, again some that were well defined and reflected the patient's current risk profile, while others had not been updated for several months.

### **Physical Environment**

Hermitage Ward is slightly bigger than the other acute adult acute in-patient areas, with a larger day area, courtyard garden and more interview rooms. All patients have their own en-suite rooms, with access to a large bathroom if required. The environment

has used colour and artwork to add to visual impact of the unit and the large windows and seats that overlook the garden add to the light and bright feel of the ward. We were pleased to see such a marked improvement with the new ward, and those we spoke to on the day commented positively on the significant improvement in the environment.

Although access and egress to the ward is locked, on the day of our visit we observed that there were members of staff available to assist patients who were able to leave the ward. We were also aware that the SCN had to actively manage the situation of asking patients not to smoke in the courtyard area.

For those patients who have been able to leave the ward on an overnight pass, we were informed that there is an issue about having a room to return to. One patient told us that they had to pack their belongings prior to leaving the ward and returned to find that they were in another room. Another patient explained that they were reluctant to go on pass due to their concern about coming back and not having a room, or being placed in another ward. We raised this with the managers of the adult acute in-patient units, and are aware that they are monitoring this situation.

### **Activity and occupation**

There was good evidence of activities available in the unit, in the hospital and accessible in the local community. We found that patients had been referred to occupational therapy, and had access to the recreation staff member, who is on the ward four days per week. We found recordings in patients care plans that identified there was access to the gym, therapy, music and art therapy sessions as well as on-ward activities such as baking groups, access to games, quizzes and pottery. It was recorded through the patients' progress notes when an activity had been offered and the engagement of the patient with the activity.

### **Summary of recommendations**

1. Managers should review and agree an accepted template, standards for care plan documentation and evaluation for the ward.
2. Managers should update the electronic patient record system, Trakcare, so that information relating to the Adults with Incapacity (Scotland) Act 2000, can be added.

### **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.

**Contact details:**

**The Mental Welfare Commission for Scotland**  
**Thistle House**  
**91 Haymarket Terrace**  
**Edinburgh**  
**EH12 5HE**

telephone: 0131 313 8777

e-mail: [enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

website: [www.mwscot.org.uk](http://www.mwscot.org.uk)

