

Mental Welfare Commission for Scotland

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

Date of visit: 26 March 2019

Where we visited

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

We last visited this service on 13 February 2018 and recommended that the templates for the care plans, and the evaluation of them, were standardised, and that the electronic record-keeping system TrakCare was updated to support documentation under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

On the day of this announced visit, we wanted to meet with patients, follow up on the previous recommendations, and also look at any difficulties for admissions related to the number of beds in the adult acute mental health services.

Who we met with

We met with and reviewed the care and treatment of nine patients and two relatives.

We spoke with clinical nurse manager, the charge nurse, and other members of the nursing team

Commission visitors

Claire Lamza, Nursing Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On meeting the patients and relatives, they described positive experiences of the care and treatment available in Hermitage Ward. Some patients that we met with, who were able to describe their stay in hospital, told us that they preferred this ward, as it was a mixed-sex environment. We were told that for some, they specifically requested to come to Hermitage.

We heard from patients that they felt they could talk to the nurses, that they felt safe while in hospital, and that staff were forthcoming and visible; those that we spoke to told us that there was always a member of staff available. The relatives that we spoke to described some challenges in relation to diagnosis and treatment solutions, but were complimentary and commented that the team have provided excellent care.

We were told by those that we spoke to that they saw medical staff, and their own doctor on a weekly basis, for others it was more frequently. We heard from the patients that there were opportunities for them to be involved in their care. We were told that being able to get out of the ward, to be able to make choices and decisions about day

to day care helped them regain a routine that they wanted to continue with after leaving hospital.

We were able to meet with a patient whose first language was not English, and where use of a translator was required. There were some challenges with obtaining someone to translate at short notice.

We also spoke to the staff about the previous recommendations, and if there was an impact on the number of beds that the ward had, and any pressures created by this.

On the day of our visit, there were 15 patients in the ward, the majority of whom were formally detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). There were a few patients who had been in the ward for several months. This was mainly due to the complexity of their needs and the challenge in finding services to support their needs following on from discharge.

There are seven consultants who have patients in Hermitage Ward. As happens with all of the adult acute admission wards in the Royal Edinburgh Hospital (REH), Hermitage Ward accepts admission from across the Lothian area, thereby the consultant psychiatrist for that area remains in contact with their patient. This is alongside the inpatient and outpatient consultants who cover East Lothian and Midlothian. This can have an impact on nursing time, in terms of keeping medical colleagues updated.

Care Plans

We found that care plans varied in terms of completion, but the overall content was of a reasonable standard. With a combination of paper and electronic records, we found that navigating between both made it difficult to see how the paper-based care plan goals related to the electronic daily progress notes. The documentation regarding legislation was stored electronically. However, there were gaps in the paper-based forms, such as the Mental Health Act form. When completed, this form provided details about advance statements, named persons, mental health officer involvement and advocacy, but the ones reviewed on the day were incomplete

On our previous visit, part of the first recommendation related to evaluation of care plans. We discussed this on the day with the charge nurse. We were told that the person-centred audit tool (PCAT) is under review, and that the audit of care plans is an identified activity for the ward team; however further work needs to be done regarding this.

Recommendation 1:

The senior charge nurse/charge nurse should implement a regular audit programme that reviews the paper-based care files to ensure that all sections are completed.

The other part of the recommendation was about standardising the documents in the care plans. Of the ones that we reviewed, we found the paperwork to be consistent and organised in the files.

We were pleased to hear about training that has been delivered in relation to care planning and risk assessment. We also thought that as part of the ward's reflective forum, the use of care plans as a basis for discussion was a helpful way of keeping the care plan connected to the actual care. Furthermore, we were told that as part of a nurse's appraisal, the review and completion of their paperwork is discussed. We thought all of these measures were useful processes for improving the quality of the care plans.

We found evidence of this in the care goals which were tailored to the patient's needs and described the goals in a detailed and personalised way. The number of goals for each patient was appropriate given that this is an acute admission ward. Of the care plans that we reviewed, patients had been given three and four care goals. There was evidence of multi-professional involvement in the care from psychology, occupational therapy, and social work/mental health officer.

Use of mental health and incapacity legislation

On the day of our visit the majority of patients in the ward were detained under the Mental Health Act, but none that were under any specified restrictions. For those that we reviewed, the relevant paperwork relating to the Mental Health Act were available on the electronic system, with a copy kept in the paper based files.

There were patients who were being treated under section 47 of the AWI Act, and who had a Power of Attorney in place. When discussing this with staff, there was a lack of clarity in their understanding of the parts of the AWI Act that were applied to patients.

Recommendation 2:

Managers should provide staff training and development in AWI legislation.

Of the files that reviewed, we found forms for consent to treatment under the Act (T2) and forms authorising treatment (T3) completed appropriately, and available on both the electronic system and a copy kept with the medication prescription sheet.

Rights and restrictions

As with the other acute inpatient environments in the REH, the main entrance/exit door to Hermitage Ward is locked, with staff being available to assist patients who wished to leave the ward, and them being able to do so promptly. There were clear pass plans in each patient's care plan, indicating time off ward, level of risk, and whether the patient was unescorted or escorted, and by whom.

We were pleased to hear about the positive risk taking practices with nurses who were able to manage risks, while skilfully supporting the patient's needs to have time off the

ward. We had the opportunity to observe this in practice. Throughout the day of our visit, there were some patients who were acutely unwell and required the intervention of nursing staff. We were pleased to see that the situations were not only managed effectively, but prior to leaving the ward, the patients who had been distressed were engaging in activities with the nurses, and a staff de-brief had taken place

All patients had access to advocacy, and, where requested, legal advice. Where there was an issue with delayed discharge, we found that the clinical team were actively engaged with the external service providers, and patients were informed and supported with their rights for information and with the complaints process.

We found a proforma in the care plans that documented whether a patient had completed an advance statement, identified their named person, and had been provided details about their rights, and their understanding of this. Of the files that we reviewed, we found that these details were not 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 information relating to a patient's rights is completed and detailed in their care plan.

Activity and occupation

There was evidence of activities available in the unit, across the hospital site, and in the local community. We found that patients engaged with occupational therapy, and had access to a member of staff with a dedicated role in the provision of on/off ward activities. There were various flyers and posters in the main day area advertising the range of different activities that patients could attend.

In discussion with, and in the patient's care plans, we found that patients and, if applicable family members, could access the Hive, music therapy and on-ward art sessions. We were told by those that we spoke to that were a range of activities that were on offer to them, and on the day of our visit, we observed staff using the principles of Health Improvement Scotland (HIS) guidance (<https://ihub.scot/project-toolkits/improving-observation-practice/from-observation-to-intervention>); when on continuous observation with a patient, we noted staff using interventions such as puzzles, games and artwork to engage the patient.

The physical environment

Hermitage ward is the only mixed sex admission ward in the REH, and benefits from being slightly larger than the other acute adult acute inpatient areas. The open plan day area/dining room, the multipurpose interview/recreational rooms, the main corridor areas with large windows, and seats add to the light and bright feel and overlook the easy-to-access large courtyard garden. All of these spaces offer different environments for the patients. The ward has been personalised with art work and items that create a conducive, homely environment.

There is a dividing section to the male and female bedroom area, where staff observe from, when required. All patients have their own en suite rooms, with access to a large bathroom if required. There is access to bedrooms throughout the day, and patients are encouraged to personalise their rooms with their own belongings.

Patients are asked to leave the ward to smoke, and on the day of our visit we did not observe any smoking in communal or outdoor areas.

Summary of recommendations

1. The senior charge nurse/charge nurse should implement a regular audit programme that reviews the paper-based care files to ensure that all sections are completed.
2. Managers should provide staff training and development in AWI legislation.
3. Managers should ensure that information relating to a patient's rights is completed and detailed in their care plan.

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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