

## **Mental Welfare Commission for Scotland**

### **Report on announced visit to:**

Royal Edinburgh Hospital, North Wing, Craiglea and Myreside wards, Morningside Terrace, Edinburgh, EH10 5HF

**Date of visit: 12 May 2016**

## **Where we visited**

Craiglea, North Wing and Myreside are the inpatient rehabilitation wards at the Royal Edinburgh Hospital. The service caters for people with mental illness and complex care needs. The wards have recently been reconfigured. Myreside was not previously a rehabilitation ward. The current Myreside units opened in March 2016

Craiglea has 18 beds for 9 men and 9 women in separate wings of the ward.

North Wing has 15 beds for men whose needs are best met in a single-sex environment.

Myreside has 12 beds comprising of a 6-bedded male unit and a separate 6-bedded female unit. These are the inpatient units of the Progressing on Both Fronts (POBF) Pilot project.

POBF is a Public Social Partnership (PSP) project between NHS Lothian, City of Edinburgh Council and Carr Gomm. Myreside is linked with Firhill which is a 6-bedded intensive community rehabilitation unit in south Edinburgh. Support is also provided by Penumbra peer support workers and Volunteer Edinburgh. We did not undertake a full visit to Firhill on this visit. However, as we were keen to see the unit, a Commission visitor went there in the afternoon. We have included comment on this below.

The wards will be closed and inpatients relocated to the Andrew Duncan Clinic after Phase 1 of the new Royal Edinburgh Hospital opens in February 2017. This will be an interim measure while new hospital and community rehabilitation services are developed.

On the day of our visit all the beds were full, other than one patient in Craiglea being in the Intensive Psychiatric Care Unit (IPCU).

We last visited the inpatient rehabilitation service on 5 June 2014. At that time the wards were North Wing, Craiglea and Albany (which has now closed). Following that visit we made recommendations about:

- recording of activity in patient files
- lack of compliance with the smoking policy by patients
- environmental issues

On the day of this visit we wanted to follow up on the previous recommendations and also to look at physical healthcare. This is because we were aware that the service reviewed aspects of physical healthcare provision in the light of some recent cases.

## **Who we met with**

We met with and/or reviewed the care and treatment of 17 patients. We also met with one patient's relative and one friend of a patient.

We spoke with the Director of Operations; Acting Chief Nurse, Interim Clinical Nurse Manager, senior charge nurses (SCNs) on all the wards, a number of staff nurses, Consultant Psychiatrist, General Practitioner (GP) and a Trainee doctor.

## **Commission visitors**

Dr Mike Warwick, medical officer (visit coordinator)

Mary Leroy, nursing officer

Margo Fyfe, nursing officer

Moira Healy, social work officer

Jamie Aarons, social work officer

Dr Gary Morrison, executive director (medical)

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

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

The atmosphere in all the wards was calm and therapeutic. Many patients went out during the day. Staff were supportive, warm and friendly to patients during all interactions we observed. Staff were knowledgeable about patients we discussed with them. Patients seemed comfortable in the company of staff.

Some people were able to discuss their care with us more than others. Patients in all the wards made positive comments to us about care and support they receive from staff. Some spoke of their involvement in their review meetings and care planning, and staff keeping them updated. People told us that they have support from advocacy.

A few people raised issues with us about their individual experiences and their care. We gave them advice about how to raise these matters on an individual basis and about their rights.

The relative we met had been concerned about the organisation of their relative's transfer to Myreside when the new unit opened. They had made a complaint to NHS Lothian. They said they were happy with the response, which had included an apology. They described having good communication with the Consultant Psychiatrist.

## **Multidisciplinary team (MDT) input, documentation and reviews**

In addition to the nursing team and consultant psychiatrist, each ward has dedicated input from occupational therapists (OTs), psychologist, GP and trainee medical staff.

Ward MDT reviews for each patient are held weekly. In all the wards there is good documentation of this meeting on a proforma which includes sections on treatment goals, synopsis of the week, the ward round discussion and future plans. There is a section for the patient's perspective, which is good practice. On some forms we saw, this contained a note that the patient had refused to participate in the process. However, there was evidence in progress notes of attempts to engage these people in their care planning.

The ward MDT review proforma had a list of disciplines that could be used to indicate who was present. However, this was not always completed. Managers should ensure that the MDT review record include names of staff in attendance, as well as their discipline.

Rehabilitation Services Integrated Care Pathway (ICP) documentation had been completed for each patient. This contains a comprehensive recovery-focussed assessment, risk assessment and care plan with detailed background information. This is good practice.

MDT reviews for each patient are held three-monthly, and an 'ICP 2 – Review of Recovery' proforma is completed. This includes reports from involved MDT members. The review is also recovery-focussed and comprehensive, and includes review of risk assessment, physical health and screening. The Glasgow Antipsychotic side effect scale is completed if applicable. This is good practice.

Daily notes were clear. In Craiglea and Myreside nursing staff routinely document daily notes under the headings 'general presentation', 'daytime activity', 'medication issues' and 'physical health'. This is easy to follow and aids comprehensive documentation. We suggest that North Wing nursing staff also adopt this practice.

We suggested that nursing staff may find it helpful also to include an approach such as SBAR (situation, background, assessment, recommendation) in their regular documentation. Nursing staff elsewhere have told us that they find this helpful for care planning.

The SCN in Craiglea told us that there has been no dedicated pharmacy input recently as the pharmacist is on maternity leave. Clearly, pharmacy input is important for this patient group. If the pharmacist is not returning soon, we suggest that managers discuss with the pharmacy department making interim arrangements.

## **Nursing care plans**

In all wards we found good, person-centred care plans with treatment goals and individualised care interventions.

Visitors to Myreside consistently found person-centred care plans in place to meet identified needs for people whose notes we reviewed.

Visitors to Craiglea and North Wing found more inconsistency in care plans they looked at. Some care plans in place would benefit from more individualised content e.g., for one individual, what works best to calm and redirect them if they are distressed.

We raised with staff the need for a patient in Craiglea to have a care plan for a particular issue. In North Wing we found that one patient had no nursing care plan for mental health issues. We discussed this with the SCN. Generally, we felt that care plans in these wards could better reflect treatment decisions made at weekly MDT meetings.

We did not find consistent records of summative evaluation and review of individual care plans.

## **Recommendation 1**

Managers should ensure that each patient has person-centred care plans to address all their mental health needs. They should ensure that staff undertake summative evaluation and review of individual care plans, and this should be audited.

## **Physical Healthcare**

We had a discussion with managers, the Consultant Psychiatrist, the GP and a Trainee doctor about physical healthcare in the rehabilitation wards. They have progressed recent developments within the service, including developing the escalation policy for staff to follow if a patient's physical condition deteriorates. Training for staff includes simulation training for medical emergencies provided by a member of the resuscitation team and a Specialist Trainee doctor. This is good practice.

The Standardised Early Warning System (SEWS) is undertaken weekly for all patients. There are three physical health champions among the nursing staff on each ward.

The GP attends each ward between 9.00am – 2.00pm on one day per week. Care she provides includes routine healthcare, annual physical health checks and screening. If a patient does not participate they are approached again later. The Adults with Incapacity (Scotland) Act 2000 is used to authorise medical treatment for those who lack capacity to consent.

On the wards we found documentation of routine physical healthcare and monitoring and healthcare provided as required. Advice on lifestyle advice and weight management is provided. Smoking cessation advice and treatment is available.

### **Advocacy, carers' group**

Patients are well supported by individual patient advocates from AdvoCard. Group advocacy meetings are held in each ward run by the Patients Council. A group for carers of patients in the rehabilitation wards is held monthly.

### **Use of mental health and incapacity legislation**

#### **Mental Health Act (Care and Treatment) (Scotland) Act 2003 – consent to treatment (T2) and certificate authorising treatment (T3) forms**

We checked whether T2 or T3 forms were in place where necessary to authorise medication for detained patients we met and some others. We found this to be the case in almost all cases, which is good practice.

One patient in Myreside required a form, and this was being arranged. One patient in Craiglea had medication prescribed that was not fully in accordance with the treatment plan on their T3, which had been written by the Designated Medical Practitioner to minimise conflict with wishes in an advance statement. We have raised this with the Responsible Medical Officer.

#### **Adults with Incapacity Act s47 certificates**

We saw s47 certificates and treatment plans in place to cover treatment where patients were incapable of consenting to this (this is not applicable for treatment authorised under the Mental Health Act). This documentation was clear, well written, and covered the treatment being given. This is good practice.

However, one s47 certificate that we saw in Myreside and one in Craiglea were out of date. We raised this with nursing staff and asked them to get the GP to attend to this. They said they would. Medical staff should ensure that s47 certificates are kept under review and that they issue a new certificate where this is required.

### **Rights and restrictions**

The doors of all the wards are locked. Staff are available to let people in and out of the wards on request (in accordance with agreed time off the ward for detained patients). In Craiglea a nurse remains in or near the Hub by the door to do this, and keeps a record of who is in and out.

We noted that there was no information displayed in any of the wards about the door being locked, and why, and how people should ask to leave the ward if they are able to. This should be available for patients and visitors.

## **Recommendation 2**

In each ward, information about the door of the ward being locked and how to ask to leave the ward should be displayed by the door.

## **Activity and occupation**

Across all the wards there is good individual activities planning and provision by OTs and nursing staff. While there is emphasis on individual and 1:1 activities, a variety of activities are provided within and outwith the hospital. These include group activities, outings and access to the Hive (an activity centre within the Hospital run by Scottish Association for Mental Health). Depending on their detention status and 'pass plan', patients are encouraged to go shopping and access activities in the community. Staff are available to accompany people off the ward if they need escorted.

Some North Wing groups are the cycling group, pool group and fishing. Craiglea groups include swimming group, football and a walking group. Patients regularly cook in Craiglea. As mentioned below, there is an issue with cookers not yet being installed in Myreside.

One patient in Myreside, although very pleasant and cooperative with nurses, often refuses to engage with them for activities. It was good to hear that they engage very well with the Penumbra peer support workers.

There is good recording of activity provision in case notes. Patients in North Wing all have their own individualised activities timetables. Patients do not routinely have these in Craiglea. We think it may be helpful to introduce this.

## **The physical environment**

North Wing is an old ward in Mackinnon House. Craiglea and Myreside were not initially built as patient accommodation. Good efforts have been made to make the best of these environments. However, there are some issues that are well-recognised by the service. As mentioned above, the wards will be closed after phase one of the new Royal Edinburgh Hospital opens in February 2017.

We will thus focus here mainly on areas that require improved or resolved to provide an adequate environment in the wards between now and their closure.

## **North Wing**

There are two single bedrooms. The other 13 beds are in dormitories, which is clearly not ideal. The dining room is used as an activity space and patients have access to tea and coffee making facilities.

One bathroom has been refurbished. The other had just become out of order and this was being attended to. The second bathroom and two toilet rooms were shabby, with cigarette burns in the flooring, etc. We were told that requests have been made to improve these three rooms. This should be progressed.

### **Craiglea**

Craiglea ward has recently been altered to include parts of the old Craiglea and Myreside wards. The ward was clean, all patients have single rooms and rooms were personalised. There is a pool table and gym equipment. Patients cook in the therapy kitchen. The environment is much improved since our last visit.

The SCN told us of the possibility of creating access from the ward to a garden. We consider that patients would benefit from this, and that this should be done.

The SCN discussed the need for bedroom window coverings to maintain privacy if access to this garden is created. We think that the most suitable coverings could be assessed on an individual basis. If screening is needed, we think that this should be one-way screening to allow the patient to see out of their bedroom window.

Four bedrooms have screening on the windows as they look over the IPCU courtyard. The SCN said that there are rooms that do not overlook the courtyard that could be used as bedrooms instead. We informed managers that we think this should be done.

One toilet in the female wing was missing a seat. We raised this on the day and managers said that this would be attended to.

### **Myreside**

The environment in the men's unit was somewhat better than the female unit. Differences included the fact that the kitchen is bigger, and decoration in the female ward looked more tired.

Women in Myreside have to go through to Craiglea if they want to have a shower (rather than a bath). They require to be escorted to do this. This rather undermines the independent living skills philosophy of the ward. We recommend that a shower should be installed in the bathroom in Craiglea.

There are, as yet, no cookers in either the male or the female kitchen. The SCN was understandably frustrated about the impact this has had on patients being able to further develop independent living skills. Cookers had been ordered but there was no delivery date. This needs to be resolved.



### **Recommendation 3**

Managers should attend to the environmental issues detailed in this report and update the Commission.

### **Plans after the current wards close**

We had discussion with managers about the future move of the inpatient rehabilitation service to the Andrew Duncan Clinic as an interim measure. At the moment, accommodation in those wards is mainly dormitory accommodation. The wards are large. We were told that consideration will be given to how best to adapt the environment to provide people with personal, private bed space.

### **Any other comments**

#### **Firrhill**

Although we did not include Firrhill in our full visit, we were keen to see the new unit. A Commission visitor went there briefly in the afternoon.

Firrhill has been open for seven weeks and provides accommodation for three men and three women in an old farmhouse. All the residents have single rooms and are supported to cook for themselves. We thought the accommodation was excellent and well situated. All the patients moved there from the Royal Edinburgh Hospital. The unit has a Carr Gomm manager and staff, Penumbra peer support workers, and NHS Lothian staff - a charge nurse, staff nurse and OT.

We spoke to two of the residents. They seemed delighted with their accommodation. They said they loved being there, although one said they were also missing being in hospital as they had been there so long.

### **Summary of recommendations**

1. Managers should ensure that each patient has person-centred care plans to address all their mental health needs. They should ensure that staff undertake summative evaluation and review of individual care plans, and this should be audited.
2. In each ward, information about the door of the ward being locked and how to ask to leave the ward should be displayed by the door.
3. Managers should attend to the environmental issues detailed in this report and update the Commission.

## **Good practice**

NHS Lothian, the City of Edinburgh Council and Carr Gomm have carefully planned the creation the POBF project in partnership. This is forward thinking and appears to be working well so far. Patients we met in the Myreside hospital units and in the Firrhill community unit made positive comments about their care in these new services.

The Rehabilitation Services ICP provides the basis for comprehensive, recovery-focussed assessment, risk assessment, care planning and review of this.

The service has undertaken considerable recent work to develop and improve systems for provision of physical healthcare in these wards.

## **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.

Mike Diamond

Executive director (social work)

## **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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