Mental Welfare Commission for Scotland

Report on announced visit to: Harlaw and Eden Wards, Royal Edinburgh Hospital, Morningside Place, Edinburgh EH10 5HF

Date of visit: 30 March 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Harlaw and Eden are 15-bedded acute assessment wards for patients over the age of 65 with functional mental illness. Harlaw is for male patients, Eden is for female patients.

We last visited both wards in 2019 as part of our national themed visit looking at older people's functional mental health wards in hospitals.

Harlaw and Eden moved to the new Royal Edinburgh building in June 2018. The new purpose-built wards offer single en-suite accommodation for all patients.

On the day of this visit we wanted to hear from patients, carers and from staff about their current experiences and about any ongoing impact of Covid-19. We had maintained regular contact with service managers from the early stages of the pandemic and were aware that older people's mental health wards at the Royal Edinburgh Hospital had been particularly affected by Covid-19, both due to the requirement to move patients and reconfigure wards at times when there were positive cases (including temporarily changing wards to mixed sex) and the added challenges of staff shortages during this period.

Who we met with

We met with and reviewed the care and treatment of seven patients on Eden ward and eight patients on Harlaw. We spoke with the service manager, senior charge nurses, and nursing staff on the ward, as well as a consultant psychiatrist. Following the visit we also spoke with the advocacy service and patients' council.

Commission visitors

Dr Juliet Brock, medical officer

Tracey Ferguson, social work officer

Gillian Gibson, nursing officer

Susan Tait, nursing officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit both wards were full. We heard from staff that there had been significant pressures on the service recently due to bed shortages across Lothian, for patients over 65 years, who required hospital admission. This had resulted in 'out of area' admissions to the wards, as well as the admission of patients with dementia to functional assessment wards. On the day of our visit 10 of the 15 women on Eden ward were in hospital for dementia care.

In addition, the wards had experienced repeated Covid-19 outbreaks, affecting both patients and staff. We were also told of nursing staff vacancies, which were further impacting on the clinical teams. We also heard that nursing staff were exhausted.

Patient/family views

The patients we spoke with were generally positive about the care they received, and about staff on both wards. We observed staff to be approachable and actively engaged with patients during our visit. One carer we spoke with after the visit said the nursing care their relative had received on Harlaw ward was "exceptional."

Following the visit, the patients' council gave us feedback from their contact with patient groups on both wards. We were told that feedback from both wards was consistently positive with both wards being "always well-regarded," with patients feeling they benefitted from being there, that staff were supportive and that the environment, accommodation and facilities were well-received. The patients' council representative also spoke of a positive culture on the wards during their visits, commenting in particular on the "open door" to the staff office, removing a barrier for patients seeking help from staff.

Case records

Patients' clinical notes are now held online on TRAK, the electronic record management system used in NHS Lothian.

We found the daily recording in patient notes to be multidisciplinary, with entries from occupational therapy and physiotherapy, as well as from nursing and medical staff. Nursing entries were variable in quality and in the level of detail provided. Although patients reported having regular one-to-one contact with their named nurse, this was not always clearly evidenced in the clinical record.

Nursing care plans

As in the previous visit, we found that nursing care plans varied in quality. Some were detailed and person-centred, others less so. We saw limited evidence of patient involvement in care planning, and whilst there was evidence that some care plans were regularly and meaningfully reviewed, this was not always the case.

We noted that the care plan format on TRAK does not currently lend itself well to mental health care planning. This is an issue we have seen widely across in-patient mental health services in NHS Lothian. We have raised this with senior managers and are assured that a review is currently taking place to re-design the online platform to better meet the needs of patients receiving mental health care. The Commission will continue to review progress in this area. In

the interim, nursing care plans could be improved to achieve a more consistent standard. We note that improvement of nursing care plans has been a consistent recommendation on previous Commission visits.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:

Managers should ensure that nursing care plans are person-centred, reflect the care needs of each person, identify clear interventions and are regularly reviewed.

Recommendation 2:

Managers should ensure patient participation in care planning is evidenced and the reason for any non-participation is documented.

Multidisciplinary team (MDT)

In addition to medical and nursing staff, the multidisciplinary teams on both wards include input from occupational therapy (OT), activity co-ordinators, music therapy and pharmacy. We were also told that members of the spiritual care team participate in team meetings. Physiotherapy is available on referral. The community Rapid Response Team (RRT) also work closely with the MDT to support discharge planning, helping to ensure continuity of care for patients moving between hospital and the community.

We found the recording of multidisciplinary team meetings generally to be of a good standard, with risk assessments updated weekly. However, the actions from MDT meetings were not always clear, particularly in relation to details and progress around discharge planning.

We were very concerned to learn that there remains no dedicated support from psychology. On previous visits we were advised that psychological therapy was available on a referral only basis, however even this resource was no longer available. We were told that the clinical psychology service were no longer accepting individual referrals due to 'resource issues' and that current advice was to refer patients post-discharge. We do not believe this is acceptable for patients admitted to an acute in-patient mental health assessment ward. This was a concern shared by the clinical team and, in particular, by the consultant psychiatrist we spoke with.

It is concerning as this represents significant inequity to this over-65 patient group. In-patient psychological therapies are available to patients admitted to adult acute wards in the hospital. When we visited the dementia assessment wards (Fairmile and Canaan) in 2021 we were advised that there was a "good level of psychology input, with clinical psychology involved in the development of formulations and behavioural support plans for individual patients, as well as supporting staff training." It is unclear why this support has not also been afforded to the older adult functional assessment wards in the hospital.

We were advised that these concerns had been escalated to the associate medical director and to the head of psychology, but that no resolution had been forthcoming.

It is notable that we have made a repeated recommendation to managers to review the need for clinical psychology input to the wards in our last two visit reports and are concerned that this deficit remains.

Recommendation 3:

Hospital managers should address the inequities in access to psychological therapies across the hospital. Patients on Harlaw and Eden wards should have the same access to psychology support as patients on other mental health wards. The Commission wishes to receive quarterly updates on action taken to address this issue.

Use of mental health and incapacity legislation

For patients who were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('The Mental Health Act'), we found legal documentation stored on TRAK.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. We found consent to treatment certificates (T2) and certificates authorising treatment under the Mental Health Act (T3) were present where required.

Where an individual lacks capacity in relation to decisions about medical treatment, a doctor must complete a certificate under section 47 of the Adults with Incapacity (Scotland) 2000 Act ('The AWI Act'). The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. One section 47 certificate, for a patient on Eden ward, was out-of-date. We also noted that certificates were not always accompanied by an individual treatment plan.

More broadly, it was not always clear if patients subject to the AWI Act had a welfare guardian or power of attorney in place. It is essential that this is clarified for every patient. For individuals subject to the AWI Act who have a welfare proxy in place, it is essential that staff have a copy of the legal documentation and are aware of any legal powers in place in relation to decisions about medical care and treatment.

Recommendation 4:

Managers should ensure that for every patient subject to the AWI Act, staff are aware if a welfare proxy is in place and if so, a copy of the document stating the powers of the proxy should be held within the case notes.

Rights and restrictions

We were told by patients, staff and a carer that we spoke with that restrictions on the ward, at times when there were Covid-19 cases, were very challenging for patients, and for relatives. Visiting in general had been highly restricted at points during the pandemic. At the time of this visit, each patient was able to have three designated visitors and one visitor was allowed per

day. Patients who were able to have passes in the hospital grounds could spend time there with visitors, if they wished.

The doors of the wards are locked to entry/exit for patient safety and there is a locked door policy in place.

Patients and staff confirmed that there is good access to individual advocacy from the hospital-based advocacy service 'Advocard'. Group advocacy meetings, facilitated by the patient's council, have also resumed following a period of absence during the initial phases of the pandemic.

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/law-and-rights/rights-mind

Activity and occupation

We were pleased to hear that both wards have an activity co-ordinator, although at the time of our visit, this input was only available on Harlaw ward two days a week, as the post couldn't be filled full-time. We were told that as well as facilitating group activities, the activity coordinators are able to provide one-to-one support to patients with more complex needs.

Patients spoke of activities taking place, including those organised by the activity co-ordinators, sessions from occupational therapists as well as art therapy and music therapy. Feedback was generally very positive, although some patients spoke of feeling bored, particularly at weekends. This was also noted by the patients' council to have been a mild criticism raised by patients in some groups.

The physical environment

The wards are bright, light and spacious and the environment clean and well maintained. The communal spaces are large and comfortable and we noted the addition of artworks around the wards, including pieces which patients had participated in making, which added visual interest to corridors and communal areas. There is a therapy kitchen on Eden ward which can be accessed by patients on both wards. There are also laundry facilities on the wards which patients can use.

The central courtyards on both wards offer a welcoming outdoor space for patients and visiting relatives to enjoy. These have space to walk, areas of planting and a variety of seating areas. On our last visit we noted the effort and attention that staff had given to make the garden environment a visually interesting and enjoyable space for the patients. We were told on this visit that early during the Covid-19 pandemic, Harlaw ward had received a grant for improvements to their outdoor space. This was used to purchase plants, install covered seating and acquire a shed and gardening tools for the patients to use. Staff and patients on both wards advised us that the outdoor spaces were enjoyed and used frequently.

Patients' bedrooms, and en-suite shower rooms are spacious, well equipped and well maintained. Two larger assisted bedrooms are available on each ward, providing facilities for wheelchair users. There is also an assisted bathroom on each ward with a hoist.

Relatives and friends can visit patients in their bedroom, in the garden, or in a room designated for visiting on each ward.

A number of patients we spoke with complained about their room being very cold. Commission visitors also noticed this. We discussed this in feedback with senior staff at the end of the visit.

Recommendation 5:

Managers should ensure that heating is adequate across the wards and that the temperature in patient bedrooms is able to be maintained at a comfortable level.

Any other comments

As on our previous visit, we were advised that delayed discharges due to challenges in identifying nursing home placements or securing community packages of care continued to be a problem. At the time of this visit we were advised of at least four delayed discharges on Harlaw ward and ten on Eden ward. This has a wider impact on the ability to admit to the ward and compounds the lack of availability of mental health admission beds for older adults across Lothian. In a few delayed discharge cases on Eden ward, we thought that referral to social work could have been made at an earlier stage (e.g. when the need for a care home placement was first identified).

There were 10 patients on the waiting list for a female bed on Eden ward at the time of this visit. In spite of this, we were advised that there remained a high turnover of patients on both wards.

Recommendation 6:

Managers should monitor and record discharge planning activity for all patients and in particular for those whose discharge has been delayed, to ensure this remains focussed and within agreed timescales.

Summary of recommendations

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Managers should ensure that nursing care plans are person centred, reflect the care needs of each person, identify clear interventions and are regularly reviewed.

Recommendation 2:

Managers should ensure patient participation in care planning is evidenced and the reason for any non-participation is documented.

Recommendation 3:

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Service response to recommendations

The Commission requires a response to these recommendations within three months of receiving this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
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 Commission 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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