Mental Welfare Commission for Scotland

Report on announced visit to:
The Royal Edinburgh Hospital, IPCU, Blackford Ward, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 22 October 2024

Where we visited

Blackford Ward is the intensive psychiatric care unit (IPCU) for the City of Edinburgh, East Lothian and Mid Lothian. It is a 10-bedded mixed-sex unit with a separate high dependency unit (HDU).

IPCUs provide intensive treatment and interventions to individuals who present an increased level of risk and require a more individualised, intensive level of observation. This type of unit generally has a high ratio of staff to individuals and a locked door. It would be expected that staff working in IPCUs have particular skills and experience caring for acutely ill and often distressed individuals.

We last visited this service in October 2023 and made recommendations in relation to managers ensuring nursing care plans are person-centred, reviewing occupational therapy (OT) provision in the ward and developing a pathway with social work colleagues to support timely allocation of a mental health officer (MHO) for detained patients.

The response we received from the service reported that new person-centred care plans were being trialled and would be implemented across the hospital site, the OT vacancy in Blackford Ward had been filled and that hospital managers had made contact with social work colleagues regarding improving MHO allocation for detained individuals.

On the day of this visit, we wanted to follow up on the previous recommendations, review the new person-centred care plan and meet individuals, family members and staff.

Who we met with

We met with and reviewed the care notes of five people. No carers or relatives wished to meet with us on the day of the visit.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), the consultant psychiatrist, occupational therapist, art psychotherapist and various members of nursing staff.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Care, treatment, support, and participation

Comments from individuals

The individuals we met on the day of the visit were mainly positive about their care and treatment in Blackford Ward. The feedback included comments such as “staff treat me well”, “staff listen to me and support me” and “it’s brilliant, the best care I have ever received”.

Individuals that we spoke with were positive about the wide range of activities available to them, commenting that they enjoyed engaging in the activities on offer. Some individuals spoke very positively about the input from art psychotherapy and the activity co-ordinators and how the interventions benefitted their care and treatment.

All individuals told us that they met with their consultant psychiatrist regularly and found these meetings supportive. Individuals told us that they felt listened to and although they did not always agree with all aspects of their care and treatment, the consultant psychiatrist took the time to explain the reasons why the multi-disciplinary team (MDT) felt the care and treatment was necessary. Individuals told us that this information supported them to gain a better understanding of the decisions made by the MDT.

Some of the individuals we met with were aware of their care plan and were able to discuss their care and treatment; others were not aware of their care plan. All individuals that we spoke with told us they felt the MDT made efforts to support their involvement in decision making regarding their care and treatment.

Some individuals told us that the ward environment could be loud and “anxiety provoking” at times. We heard that there was verbal, and at time physical, altercations between the patient group which could be “frightening”. We were pleased to be told by individuals that during periods of high acuity in the ward, staff offered enhanced support which helped individuals to feel “safe”.

Although we did not speak to any carers or relatives on the day of the visit, we saw carers group information displayed in the ward.

Comments from staff

We heard that the staff team in the ward had changed significantly since the last visit. There was a new SCN and charge nurse in post. Many more experienced staff nursing staff had moved from Blackford Ward to pursue new promoted posts. We heard that eight newly qualified nursing staff had recently started in the ward.

Staff told us that they were happy in their role and commented that the addition of new staff supported a positive working culture, new skills and experience to the

MDT. We heard that having new team members had improved staff morale, especially when there had been higher levels of staff vacancies for a prolonged period of time. We were told that although many of the new staff were newly qualified staff, there remained a balance of experienced and skilled staff in the MDT.

All staff that we spoke with felt supported by the ward management team. Staff reported that the SCN had created an ethos in the ward that promoted commitment to providing high standards of care to individuals and that they had supported staff to enable them to provide high quality patient care.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

We made a recommendation following the previous visit that nursing care plans in Blackford Ward should be more person-centred and contain individualised information. The service response reported that new person-centred care plans were being implemented and we were keen to review the new care plans and determine if the template had supported the recommendation made. We heard from the senior management team that there had been a delay in the implementation of the new person-centred care plans, and that the date for implementation would not be until early 2025.

We reviewed five nursing care plans which were stored electronically on TrakCare. Despite the delay with the new care plan system, we were pleased to find an improvement in the quality of the care plans in Blackford Ward.

From the files we reviewed, all individuals had at least four care plans recorded in relation to mental state, physical health needs, violence and aggression and activity/occupation. Some individuals had additional care plans, for example, art therapy care plans, depending on the care and treatment needs and risk assessment. The majority of care plans covered a range of care needs, goals and outcomes identified from risk assessments and assessments completed by various members of the MDT for example, OT and physiotherapy. The care plans we reviewed were holistic, they evidenced strengths-based goals and outcome-focussed interventions. Physical health and violence and aggression care plans in particular recorded comprehensive and personalised information. This information promoted care plans that were individualised and person-centred.

The participation of the individual was not consistently evident in all care plans we reviewed. Some of the individuals we met with told us that they were unaware of their care plan. However, we saw that information from one-to-one interactions with

nursing staff and from discussions with family members, where appropriate, was reflected in the care plans.

We saw regular review of care plans. We found some examples of reviews that included summative evaluations regarding the efficacy of an intervention, as well as an individual's progress or where there were areas that needed increased care. There were other reviews that did not include this level of information, therefore making it difficult to see if the individual was making progress towards their admission aims, objectives and care goals.

We were pleased to find that discharge planning and dates were discussed and set from the point of admission and took place at MDT meetings and during senior medical reviews. We were pleased to find that all members of the MDT were involved in the discussion and decision making to support discharge planning.

We reviewed five risk assessments and found the quality of information contained in the risk assessments was inconsistent. In some of the risk assessments we reviewed, we found detailed information on historical risk, current risks and safety plans to manage and support identified risks. Other risk assessments did not have the same level of comprehensive information on what the identified risk was and safety planning that was required to manage the risks.

We noted that some of the risk assessments reviewed were for individuals who were recently admitted to Blackford Ward, therefore further assessment was required to inform ongoing risk assessment and risk management. We saw that for another individual, they had been transferred to the IPCU from another ward in the Royal Edinburgh Hospital (REH). For this individual, their risk assessment was commenced by staff in the admitting ward and very little additional information had been added since their admission to Blackford Ward. This made it difficult to ascertain if the original risks identified and safety plan remained relevant.

We found that in addition to the risk assessments, care plans on violence and aggression and pass plans had been completed. The information recorded in these documents were of high quality and evidenced the risk assessment.

We discussed the inconsistent risk assessments with senior managers on the day of the visit. We advised that that the current template on TrakCare used to record risk assessments did not support clear recording of current identified risk factors and safety planning. The SCN agreed that an urgent audit of all risk assessments was required to ensure there was consistency of in the quality of information documented in all individuals risk assessments. We look forward to seeing an audit process being implemented for this at our next visit.

We saw that physical health care needs were being addressed and followed up appropriately. Since the last visit, an advanced medical practitioner (AMP) had been

recruited and has supported the implementation of physical and mental health assessments across the acute wards in the REH.

In addition to the AMP, medical reviews were completed by the core trainee medics and were of a high standard. The reviews undertaken by the core trainees included comprehensive information that was personalised and included forward planning of care and treatment.

Care records
The majority of care records were recorded on a pre-populated template with headings relevant to the care and treatment of the individuals in Blackford Ward. On review of the care records, we were pleased to find key information recorded at the top of the care record page.

The care records included comprehensive and individualised information from all members of the MDT. The information recorded was person-centred, strengths based, outcome and goal focussed and included forward planning. This strengths-based approach was also evident during more challenging circumstances, such as following incidents of aggression.

It was evident from reading the care records how individuals spent their day, what members of the MDT had interventions with them and the outcome of interventions. The canned text headings were used to their full potential which promoted a holistic and trauma informed approach to the care of individuals in Blackford Ward.

We saw detailed admission summaries for individuals. We were concerned to read some complex and challenging admission circumstances. One individual told us that they were advised that they needed IPCU care however, due to a shortage of IPCU beds across Scotland, they had to remain in a prison segregation environment for a prolonged period of time which had caused high levels of stress and distress for the individual. The nursing staff reported that delays with an admission to Blackford Ward caused the individual's mental health to deteriorate further making it difficult to treat symptoms. The individual was of the view that the delay in accessing an IPCU bed had had a negatively impact on their recovery.

There was evidence of frequent one-to-one interactions between individuals and all members of the MDT. The individuals we spoke with told us that they met with nursing staff and other members of the MDT regularly. The one-to-one interactions we reviewed were comprehensive. We liked the use of 'how are you' in the one-to-one template, as it supported an objective conversation with individuals that gave them the opportunity to their provide views in relation to their care and treatment. We were pleased that information from these one-to-one interactions was reflected in the nursing care plans and MDT discussions.

We were pleased to see detailed care recordings from various members of the MDT. In particular, the care records from medical staff were of a high standard. We were impressed by the regular review of individual's mental health by the consultant psychiatrist. The care records we reviewed recorded by medical staff were thorough, person-centred and evidenced a rights-based approach.

We saw from review of the care records that there were high levels of clinical acuity. We also saw, and observed, regular incidents of acuity of mental ill health, violence and aggression that required high levels of input from all members of the MDT.

We were pleased to find that the care records included regular communication with families and relevant professionals, including community teams.

Multidisciplinary team (MDT)

The unit had a broad range of disciplines either based there or accessible to them. In addition to medical and nursing staff, the MDT was made up of two activity co-ordinators, AMP, pharmacy and art psychotherapist. We also heard that the ward had regular input from MHOs and spiritual care services.

There was no psychology based in the ward. We were told that when psychology input was required, a referral was made to psychological services. It was evident from discussions with the individuals and from review of the care records, that the MDT offered specialist and holistic care and treatment to individuals in the IPCU setting.

A recommendation was made in the previous two reports in relation to OT being part of MDT. We were pleased to see that this recommendation has now been actioned. We saw from our review of care records and from speaking with individuals that the OT was involved in functional and needs assessments.

We met with the OT who told us that there was OT cover in Blackford Ward three days a week. The OT told us they worked with individuals, giving the example of supporting passes off the ward to assess individuals' abilities in areas such as road safety and money management. We were also told that the OT had arranged group work to support therapeutic interventions with individuals in the ward however, clinical risk determined whether group work could be safely provided. The OT was also involved in supporting discharge and liaised with social work and housing to assist in arranging packages of care in the community that support discharge.

We met with the art psychotherapist on the day of the visit. We were told that art psychotherapy provided support on a one-to-one and group basis. We heard that art psychotherapy supported the individuals' communication which was helpful to inform their care plan, risk assessments and promote the MDT adopting personalised and therapeutic informed interventions. The art psychotherapist also helped with conflict resolution in the ward setting by developing alternatives ways of

individuals expressing their emotions and relating to others which assisted in improving relationships between the individuals in the ward.

The MDT met weekly in the ward. In attendance at the meeting were medical staff, nursing staff, pharmacy and at times, OT. Members of the MDT who were unable to attend the meeting recorded information on the MDT recording template prior to the meeting. The MDT meeting was recorded on TrakCare on the mental health structured MDT template. The template had headings relevant to the care and treatment of the individuals in Blackford Ward.

We found the MDT meeting records were of an excellent standard. The information recorded in the MDT records was comprehensive and contained detailed recording of the discussion, decisions and forward planning that took place. We were pleased to find that in addition to discussions on an individual's mental health, the MDT focussed on physical health, legal status, rights-based care, socioeconomic and cultural factors. This promoted a holistic and trauma informed approach to the individual's care. It was evident that everyone in the MDT was involved in the care of the individuals in Blackford Ward and committed to adopting a holistic approach to care and treatment.

There was evidence of clear links between MDT discussions and care plan outcomes. There was discharge planning for some of the individuals we reviewed. For these individuals, there was evidence of the MDT liaising with key community professions, such as social work and housing to facilitate and support discharge.

We saw that individuals did not attend the MDT meeting. We were told and saw from the care records that the consultant psychiatrist met with the individuals at least once a week to discuss their care and treatment plan, to discuss outcomes of the meeting and the decisions that were made. We also saw that during one-to-one interactions with nursing staff, individuals were asked for their views on their care plan and this was reflected in the MDT discussions. Individuals that we spoke with were happy with this arrangement, reporting that they felt involved in discussions and decision made regarding their care and treatment.

In relation to carer/relative involvement, we noted that when family were involved with an individual's care, separate family meetings were arranged.

Use of mental health and incapacity legislation

On the day of the visit, 10 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). The people we met had a good understanding of the Mental Health Act and were aware of their right to appeal. Some of the people we reviewed had a named person. We were able to locate all documentation relating to the person's detention on TrakCare.

During our last visit, we found that many of the individuals who were subject to the Mental Health Act did not have an allocated MHO. We were concerned that specific MHO duties and responsibilities set on in the Mental Health Act were not being undertaken which negatively impacted on the individual's rights. We made a recommendation that health and social work colleagues should develop a pathway to ensure timely allocation of an MHO. We were pleased to find that progress had been made and most of the individuals in Blackford Ward had an MHO and had regular communication with their allocated MHO.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed. We reviewed the prescribing for all individuals, as well as authorisation of treatment for those subject to the Mental Health Act. We discussed some queries with senior medical staff and these were resolved on the day of the visit.

Medication was recorded on the electronic prescribing system HeMPA (hospital electronic prescribing and medicines administration). T2 and T3 certificates authorising treatment were stored separately on TrakCare. It is a common finding on our visits that navigating both electronic systems simultaneously can be a practical challenge for staff. This is potentially problematic, as it can reduce the ease of checking the correct legal authority is in place when prescribing and dispensing treatment for those who are detained. On our visit to Blackford Ward, we again found this to be the case and for this reason, we advised to the SCN that a paper copy of all T2 and T3 certificates should be kept in the ward dispensary, so that nursing and medical staff have easy access to this, and there is an opportunity to review all T2 and T3 certificates. The SCN agreed to action this, and we look forward to seeing this at our next visit.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found it easy to locate all documentation recorded on TrakCare.

Rights and restrictions

Blackford Ward continues to operate a locked door, commensurate with the level of risk identified with the patient group.

The majority of the individuals we met with had good knowledge of their rights. We saw that each detained individual had received a letter from medical records following detention under the Mental Health Act that included information on their

detained status and their rights in relation to this. We found that most individuals had legal representation and support from advocacy.

We noted that some individuals had exercised their rights and had appealed the legal order they were subject to.

We were concerned to hear that there had been an increase in the number of admissions to IPCU for individuals who were not subject to detention under the Mental Health Act. We were told that this was due to a shortage of beds across the REH hospital site. Although there were no individuals in the ward on an informal basis on the day of our visit, staff raised concerns over the level of restriction informal patients were subject to in the IPCU setting. We saw that for individuals who agreed to be admitted to the IPCU, they were provided with information about the ward environment and signed a consent form, consenting to admission to the IPCU, after medical review and discussion with their consultant psychiatrist. We were told that informal patients in the IPCU were reviewed regularly and prioritised for a bed in an acute ward.

We were pleased to find ongoing improvements had been made to support a proactive approach to the delivery of rights-based care. We were pleased to see additional information on rights displayed and available to individuals throughout Blackford Ward.

In particular, we found the information board displayed at the entrance of the ward provided excellent information on the Mental Health Act, criteria for various mental health orders, individuals rights when subject to orders and how to exercise their rights. As well as written information, the information board included QR codes to the Commission's website, to support the individual getting access to further rights-based information.

We heard from individuals that they found the levels of restrictions placed on them in an IPCU setting difficult at times. We were pleased to hear that the art psychotherapist had a role in discussing restrictions with individuals in the ward and supported them to understand reasons restrictions were in place and their rights.

Blackford Ward has a high dependency unit (HDU). We heard that the use of the HDU had reduced significantly however, there were still occasions when seclusion in the HDU was required to support individuals who were displaying extreme stress and distress. The HDU was being used on the day of the visit for an individual. We saw that the individual was being closely monitored and reviewed by the MDT and senior medical staff. The recording of the use of HDU was comprehensive, recording clearly why seclusion was required and reviewed regularly.

We found that where continuous intervention (CI) was required, this was proportionate to the assessed need and risk, the CI was reviewed regularly by the

MDT to assess its effectiveness and ensure the intervention was responsive and personalised.

Sections 281 to 286 of the Mental Health Act provide a framework in 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 Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. One individual was specified on the day of the visit. Where specified person restrictions were in place under the Mental Health Act, we found detailed reasoned opinions and regular reviews of the restrictions in place.

The Commission has produced good practice guidance on specified persons[1].

The ward held regular community meetings called 'The Blackford Blether' facilitated by the activity co-ordinators. The meeting provided an opportunity for individuals to give feedback on what was good in the ward and suggestions for improvement. The meeting discussed any achievements that either individuals or staff had accomplished. The individuals enjoyed giving out awards to celebrate these successes.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We found did not find any advance statements in the care files reviewed. Some of the individuals we met with were aware of advance statements however, had chosen not to complete one. Other individuals were unaware of advance statements. It was evident from review of the individual's files and during discussion with some of the individuals that they were not at a point in their recovery to be able to make decisions regarding their care and treatment.

We were told that advocacy had regular input to the ward provided by 'Advocard'. We were told that advocacy attended the ward on request and provided a good service to individuals who wished to engage with them. We were pleased that the individuals we met with and reviewed on the day of the visit either had or had been offered advocacy support.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512
[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Blackford Ward had two activity co-ordinators, an increase in provision since the last visit. We were pleased to be told that activity and occupation was offered to individuals seven days a week. Although activity and occupation in the ward was mainly provided by the activities co-ordinators, nursing staff, OT, the art therapist and volunteers also supported activity on the ward.

The individuals we met with spoke very positively and were complimentary about the activities and occupation that was available to them. Many of the individuals commented that there was a wide range of activities available and that they were able to engage in activities that they liked and had an interest in.

A weekly timetable was displayed in the ward noting activities on offer. The activities available included art psychotherapy, therapet session, music group, arts and crafts, mindfulness session, fitness sessions, jewellery making, pool tournament, spa session, quizzes, PlayStation and movie nights. We heard that some individuals attended the HIVE day service, an activity centre situated in the grounds of the hospital.

During the last visit, we commented that we would prefer activity information to be recorded in care records alongside the rest of the MDT's information. We were pleased to see this had been actioned under a specific activity heading on the canned text. We found the recording of activities to be of good quality, detailing person-centred information on how the individual found the activity, what was positive for the individual and areas which they found challenging and needed support.

The physical environment

Blackford Ward is a mixed-sex IPCU therefore the physical environment must be managed to support individuals to feel safe and comfortable in the ward setting. The bedroom areas in the ward are divided into male and female zones. Each bedroom has en-suite facilities and we noted that individuals could personalise their room if they chose to.

The cleanliness of the ward was of a high standard. The ward had a range of spaces available for individuals to use such as male and female lounges, art room, games room and a dining area. Additional equipment such as a PlayStation and karaoke machine had been purchased for the games room since the last visit. We heard that the addition of this equipment had made the room very popular with individuals and most tended to congregate and spend time in this area.

Areas of the ward environment, specifically the male and female lounges, would benefit from some areas of improvement to promote a less clinical and more welcoming, homely and therapeutic environment.

The ward had an OT therapy kitchen however, we were told this was not used due to concerns raised in relation to safety issues. The main OT assessment kitchen based in another area of the REH could be used if a kitchen assessment was needed. The SCN told us that the use of the OT kitchen in the ward was under review and consideration was being given as to how this space could be used to benefit the individuals in Blackford Ward.

There was a courtyard garden area that was easy for individuals to access. Individuals could access the garden area throughout the day and until late evening.

Summary of recommendations

The Commission made no recommendations, therefore no response is required.

However, we would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. We will contact the service in three months' time to gather feedback about this.

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 an individual's care, treatment, and support are 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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