Mental Welfare Commission for Scotland

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

Date of visit: 25 November 2024

Where we visited

Braids Ward is a 15-bedded, mixed-sex ward that provides care to adult acute inpatients between the ages of 18-65 years old. The ward predominantly focuses on complex discharges which are assessed through the referral system on transfer to the ward.

The overall ward dynamic is a mixture of both physical and mental health diagnoses which is managed by the multidisciplinary team (MDT). This helps to support the individual's overall recovery pathway, promoting the best interests of all those involved.

On the day of our visit, there were 15 people on the ward and no vacant beds. We heard and saw that for nine of the individuals in Braids Ward, their discharges had been delayed due to several factors, including issues with transitions to other wards in the Royal Edinburgh Hospital (REH) site, and difficulties sourcing community care and housing.

We last visited Braids Ward on 4 December 2023 on an announced visit and made recommendations in relation the authorisation of medical treatment and completion of section 47 certificates. The response we received from the service reported that the authority to treat and section 47 certificates would be reviewed at the weekly MDT meeting and audited by the senior charge nurse.

On the day of this visit, we wanted to follow up on the previous recommendations and meet with individuals, relatives, carers and staff and look at the care and treatment being provided on Braids Ward.

Who we met with

We met with, and reviewed the care of seven people, who we met with in person and reviewed the care notes of six. We also met with one relative.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), nursing staff, the art psychotherapist and the recreational nurse.

Commission visitors

Kathleen Liddell, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

Comments from individuals

The individuals we spoke with on the day of the visit provided extremely positive feedback about their care and treatment in Braids Ward. Feedback included, “staff are phenomenal and provide me with excellent care”, “staff are kind, caring and take the time to listen to me”; one individual reported “personal care support left me feeling dignified”. Another individual told us that they had had “the best holistic care I have ever received”.

All individuals told us that staff were always available to them, and they were offered regular one-to-one support from various members of the MDT, which they felt that they had benefitted from.

Many of the individuals we spoke with told us that the input from the full MDT had provided them with opportunities to receive specialist skills-based interventions that had supported the recovery of their mental and physical health. Individuals commented that their care was person-centred and that they felt involved in discussions and decisions about their care and treatment.

All individuals spoken with commented on the ‘calm’ atmosphere in the ward and how this had made them feel safe. All individuals told us that there were ‘excellent’ opportunities to engage in a range of activities that were connected to their likes, goals and skill development. We heard that some individuals felt their confidence in skills-based activities such as cooking had increased, and others commented that the input from the recreational nurse had promoted their independence and self-esteem to engage in more community-based activities.

We heard from some individuals that they felt frustrated that they had been in hospital for long periods of time and although they were aware of their discharge plan, they were not aware of timescales and felt that there was a lack of proactive planning to facilitate their discharge.

Comments from family

The family member we spoke with reported that they felt the care and treatment that their loved one had received had been very good. We heard that the family member felt involved in decision making and that their views were listened to. We were told that communication with ward staff was “very supportive” with regularly updated information being provided to family members.

We heard that staff were “very kind and welcoming” and made family members feel comfortable in the ward.

We were told the family member felt involved in discharge planning and although the plan was not what the family member would have hoped for, we heard that the MDT

met with the family member to discuss and explain why the decisions had been made to support the care and treatment needs of their loved one. The family member commented that this supported them to understand and agree with the discharge decisions.

We heard that there was a carers group held in the Royal Edinburgh Hospital site once a month. This group was facilitated by staff from Braids Ward and helped promote the voice of carers.

Comments from staff

We met with various members of the MDT during the visit. All of the staff that we spoke with told us that they enjoyed working in Braids Ward and felt supported to undertake their role. We heard from staff that there was “a great team” in Braids Ward and that this enabled staff to feel happy and content at work.

We were advised that staff were offered reflective practice from the art psychotherapy team and found this input beneficial.

The staffing team in Braids Ward was fully recruited to and that there was a good level of experience and skill mix in the current staff team. We were pleased to hear that the use of bank staff was minimal and that there was a consistent approach to the care provided to individuals in the ward.

Care, treatment, support, and participation

Nursing care plans

Nursing care plans are a tool that identifies detailed plans of nursing interventions; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress that has been made.

The care plans that we reviewed provided comprehensive information. Each individual had several care plans in place that were holistic and covered a range of needs identified from risk and functional assessments. The purpose of the admission was clear, and the care plans included information on the nursing interventions required to meet the care goals.

We saw that a comprehensive assessment (CANVAS) had been completed on admission which provided historical and personal information regarding the individual. This information was evident in the care plans and supported the care plans to be individualised, strengths based and person-centred. The care plans adopted a holistic approach from the MDT.

Most of the individuals spoken with were aware of their care plan and there was evidence of their and their family’s participation, where appropriate, in the care planning.

We saw regular reviews of care plans that provided detailed information, including summative evaluations regarding the efficacy of targeted nursing interventions, as well as the individual's progress. We saw that individuals had participated in their reviews. We were pleased to find that some of the individuals we met had made significant progress and were near to discharge.

We saw that physical health care needs were being addressed and followed up appropriately by the clinical fellow based in the ward. The completed medical reviews were of a high standard. The reviews undertaken by the clinical fellow included comprehensive information that was personalised and included forward planning for care and treatment.

We found the risk assessments that had been reviewed and were of a good standard. The risk assessments contained information on past and current risk. They recorded protective factors, stressors and a risk management plan that detailed how the risk should be managed and the interventions required. We saw regular MDT reviews of the risk assessments and changes made to the management plan to reflect either new or reduced risk.

Each individual had a pass plan that detailed the agreed pass arrangements and interventions required to support their time off ward.

Delayed discharge

There were nine individuals' whose discharge had been delayed for an extended period of time. The term 'delayed discharge' refers to when a person who is clinically ready for discharge from inpatient hospital care, continues to occupy a hospital bed, usually because of delays in securing a placement in a more appropriate setting. While the Commission acknowledges that some issues remain out with the control of the health authorities responsible for the care of individuals, discharge planning should begin on admission. Delayed discharges impact negatively on both the individual who is delayed, as well as on those individuals who require admission to specialist areas but are unable to be admitted due to lack of beds.

We were told that the delays to discharge were mainly in relation to delays in transferring individuals to other areas of the hospital site and also delays in securing appropriate housing and care packages in the community. On review of the care records and from discussions with individuals and staff, we saw efforts to promote discharge planning however, we did not find the current approach used the SMART (specific, measurable, achievable, relevant and timely) principles, leading to discharge planning not providing evidence of clear and actionable plans that were achievable in a certain timeframe.

During our previous visit, we raised our concerns that there was a lack of social work attendance at the MDT meetings. Discussion and decisions regarding discharge

were regularly held at MDT meetings, with many of the actions from the meeting relating to social work. We did not consider this arrangement as supportive of a fully collaborative approach to proactive discharge planning as was required. We were advised during the previous visit that having a dedicated social worker in the MDT was being considered; it was agreed this role would add value, given the remit of the ward was complex discharge.

We were disappointed that no progress had been made to the social work role being fully integrated into MDT. We were unable to identify what model of communication was being used by health and social work colleagues to promote a fully collaborative MDT approach in supporting discharge.

Feedback from some individuals indicated that they felt frustrated at the length of time in hospital and the lack of discharge progress. We were pleased to see that support was being offered to these individuals by nursing staff and the art psychotherapist to enable individuals to express their frustration and support them to develop coping strategies to manage these feelings.

Recommendation 1:
Managers should ensure that a pathway is developed in partnership with social work colleagues to support a fully collaborative approach to discharge planning.

A copy of this report will be sent to City of Edinburgh senior social work managers.

Care records
Information on care and treatment was held electronically on TRAKCare. We found this easy to navigate. The majority of care records were recorded using canned text, a pre-populated template with headings relevant to the care and treatment of the individuals in Braids Ward. We noted that care provided during night shift was not recorded on canned text. We raised with the CNM and SCN that to support consistency of care, we would prefer to see all information recorded on canned text.

It was evident from reviewing the care records that individuals had a diverse range of care and treatment needs. We saw that for many, they had co-morbid conditions. We were pleased to see regular reviews of physical health care from medical staff, annual health checks being carried out and referrals to other services such as primary care, speech and language therapy, physiotherapy and addiction services where required.

We saw that some individuals required high levels of support and / or motivation with activities of daily living. We were pleased to see a range of nursing skills offered on the ward to meet the complex physical and mental needs of the individual and that the care and support being provided aligned to care plan outcomes.

The care records we reviewed were of good quality, personalised, and evidenced a person-centred and strengths-based approach. The care records detailed what activities the individual had participated in that day, their level of engagement and any challenging and / or positive aspects of the day.

We were pleased to see comprehensive recording from all members of the MDT. The care records from occupational therapy (OT), medical staff, recreational nurse, physiotherapy, and art psychotherapist were personalised, outcome and goal focussed and included forward planning. The care records evidenced a holistic approach being offered to individuals in Braids Ward.

There was evidence of one-to-one interactions between individuals and nursing staff and other members of the MDT. The one-to-one interactions we reviewed were comprehensive and personalised. We saw that individuals were discussing their views on their care and treatment with staff nursing one-to-one interventions.

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

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a part-time consultant psychiatrist, a clinical fellow, an art psychotherapist, a recreational nurse, an OT and OT assistant. There was also access to physiotherapy, pharmacy, dietician, spiritual care, phlebotomy, social work, and psychology. Together, the MDT had an extensive range of knowledge, skills and experience in completing complex discharges in a robust and safe way.

We heard that there had been a change in the MDT meeting structure. During the last visit, the Commission highlighted that individuals did not attend the MDT meeting. We reported that some of the individuals raised this during our previous visit, telling us that they did not feel fully involved in the discussion and decision-making regarding their care and treatment. We discussed with the CNM and SCN that a review the current MDT arrangements should take place in order to promote greater participation of the individual at the MDT meeting.

We were pleased to see that individuals were provided with the option to attend the MDT meeting if they wished. The individuals spoken with during the visit told us that they preferred being given the option to attend the MDT. For those individuals who did attend, their experience was positive, and they reported that their views were listened to, and they felt involved in decisions regarding their care and support.

We found detailed recording of the MDT discussion and decisions set out on the structured ward-round template. Most members of the MDT either attended the meeting or provided information to the MDT. There was evidence of clear links

between MDT discussions and care plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission. It was clear that everyone in the MDT was involved in the care of the individuals in Braids Ward and were committed to adopting a holistic approach to care and treatment.

In relation to carer/relative involvement, we heard and saw that when family were involved with their relative's care, and their views were sought and taken into account during MDT discussion.

Use of mental health and incapacity legislation

On the day of the visit, 13 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). The people we met with generally had a good understanding of the Mental Health Act and were aware of their right to appeal.

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. Some of the people we reviewed had nominated a named person. We were able to locate all documentation relating to the person's detention on TRAKCare.

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. We made a recommendation following the last visit in relation to consent to treatment (T2) certificates and those authorising treatment (T3 certificates) as we found that some individuals were prescribed treatment that was not legally authorised. The service provided a response that all consent to treatment certificates would be reviewed in the weekly MDT and audited by the SCN.

We reviewed the prescribing for all individuals, as well as authorisation of treatment for those subject to the Mental Health Act and were concerned to find there were a number of individuals who had medication prescribed which was not authorised by the T2 or T3 certificates. We raised this with the CNM and SCN on the day of the visit and requested an urgent review of all T2 and T3 certificates. We provided advice on informing the individual and named person of the period of unauthorised treatment and their rights in relation to this. We are therefore repeating our recommendation from last year.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment and introduce an audit system to monitor this.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland), 2000 Act (AWI Act) must be completed by a doctor. 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.

On our last visit, we were unable to locate a section 47 certificate, and some did not have an accompanying treatment plan. We made a recommendation in relation to this and were advised by the service that a review of all section 47 certificates would be completed, and a regular audit would be undertaken. We were concerned to find that on review of the four section 47 certificates granted two individuals did not have an accompanying treatment plan. We raised this with the SCN on the day of the visit and requested that treatment plans were completed as a matter of urgency. We are therefore repeating this recommendation.

Recommendation 3:
Managers and the responsible medical officers must ensure individuals who lack capacity in relation to medical treatment have Section 47 certificates and where necessary, treatment plans completed in accordance with the AWI Code of Practice (3rd ed.), to cover all relevant medical treatment the individual is receiving.

Rights and restrictions

Braids Ward continued to operate a locked door commensurate with the level of risk identified with the patient group. The ward had a locked door policy that was displayed at the entrance door.

The majority of the individuals we met with had good knowledge of their rights. We noted that individuals who were detained received a letter from medical records following a detention under the Mental Health Act; this included information on their detained status and their rights in relation to this. Most individuals had legal representation and support from advocacy. We found that some individuals had exercised their rights and had appealed their legal order.

We suggested during the previous visit that on Braids Ward, they should consider ways of increasing awareness and promotion of rights. We were pleased to find improvements had been made to support a proactive approach to the delivery of rights-based care.

We were pleased to see increased amounts of information on rights displayed and available to individuals throughout Braids Ward. In particular, we found the information board that was on display in the communal area 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 that supported the individual getting access to further rights-based information. We were also pleased to see the addition of a care record that promoted discussion with the individual regarding their rights. It was evident from our review of the care records that there was regular discussion with the individuals in Braids Ward in relation to their rights and how to exercise them.

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 an individual is made 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. Two individuals were specified on the day of the visit.

Where specified person restrictions were in place under the Mental Health Act, we found comprehensive reasoned opinions and regular review of the restrictions in place. During discussion with individuals who were specified under the Mental Health Act, they reported that they were involved in regular discussion reviewing the restrictions.

The ward held regular community meetings facilitated by staff. The meeting provided an opportunity for individuals to give feedback on what was good in the ward, activities they would like arranged and suggestions for improvement. We also saw a suggestions board located in the communal area that recorded what had been provided by individuals.

When we are reviewing individual's files, we look for copies of advance statements. The term 'advance statement' refers to a written statement 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 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. We were pleased to see that advance statements were discussed on the completion of the CANVAS assessment and during the rights discussions with nursing staff.

We were told that advocacy was provided regularly in the ward by 'Advocard'. We were advised that advocacy attended the ward on request and provided a good service to individuals who wished to engage with them. We were pleased to note that the individuals we had met with and whose care we reviewed on the day of the visit either had, or had been offered, advocacy support.

The Commission has developed *Rights in Mind.*[1] 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.

Activity and occupation

We heard and found evidence of a broad range of activities that were available for individuals in Braids Ward. The activity and occupation in the ward was mainly provided by the recreational nurse, however, activity was also supported by nursing staff, the art psychotherapist, OT's and volunteers.

We met the recreational nurse on the day of the visit; they had been in post for four months. The recreational nurse had introduced a 'what matters to me' document which was completed by individuals who provided information on their activity preferences, goals and outcomes in the ward environment and in the community. This information was reflected in the activity care plan completed by the recreational nurse which promoted a person-centred approach to activity and occupation.

There was an activities board situated in the communal area of the ward; this displayed the weekly timetable of what was on offer. The activities available included arts and crafts groups, baking and pottery groups, music jam, attending the library, walking group, therapet, attending the library.

Community outings were also available, and we heard that outings to the National Gallery had taken place and there was a planned activity to the Christmas markets that individuals were very positive about. We heard that some individuals attended the HIVE day service, which was an activity centre situated in the grounds of the hospital. We were told by the recreational nurse and individuals that we spoke with that the activities available were reviewed weekly and changes made to reflect the needs and preferences of those in the ward.

We saw and heard that OT were involved with many individuals in Braids Ward. We saw from our review of the care records that initial and functional assessments completed by the OT informed the care goals and interventions required. We were pleased to see skill development opportunities being provided to some individuals which supported future discharge planning.

Art psychotherapy was offered in Braids Ward. We heard that the art psychotherapist offered a weekly open group and one-to-one sessions to individuals. We were told that art psychotherapy provided an opportunity for individuals to explore and reflect their thoughts and feelings and use art as a way of communicating and processing difficult thoughts and feelings.

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We found all activity was recorded on TRAKCare and the records were of a high standard, personalised and provided comprehensive information on the purpose and goal of the activity, how the individual presented during the activity and future planning.

The physical environment

Braids Ward is a mixed-sex environment, therefore the ward had to be managed differently from other single-sex wards in the hospital, to ensure that individuals felt safe and comfortable in the ward setting. The bedroom space in the ward was divided into male and female areas. Each bedroom had en-suite facilities and we heard and observed that individuals could personalise their room if they chose to.

The cleanliness of the ward was of a high standard. The main space used by those in the ward was the open plan communal TV/dining area. This area had artwork and Christmas decorations on display which promoted a homely and welcoming environment. There was a beautiful art mural leading to the communal area which had been completed by individuals in the ward and staff members. Individuals were able to use the kitchen facilities to make a hot drink and snack and had access to the outside courtyard from the communal area.

Where appropriate, there was a therapy kitchen and laundry room that individuals could use to support developing skills.

The ward environment was calm, welcoming, and settled on the day of the visit. From the individuals and the relative that we spoke with, we heard that the atmosphere of the ward was generally friendly and calm and that staff spent a lot of time being accessible and visible, which supported individuals to feel safe and develop therapeutic relationships with staff.

We highlighted in the previous report that the small sitting room, a space used by individuals when they required a less stimulating environment, was clinical and required some improvement to create a more therapeutic space.

We were disappointed to see that there had been no improvements made to this space and we heard that this room was, at times, used as a bedroom. On the day of this visit, the sitting room was not being used as a bedroom although there was a mattress stored there.

We raised our concerns with the senior management team in relation to the room being used as a bedroom, as it did not have washing or toilet facilities; we consider this to compromise the rights of an individual in terms of their privacy and dignity. Although we recognise the national shortage of mental health beds, we did not consider this room to be an appropriate, or safe, bedroom.

Furthermore, we were concerned that by using this space as bedroom, it limited the therapeutic and quiet space available on the ward for other individuals to use. We would suggest that individuals benefit from having an alternative therapeutic space to utilise.

Summary of recommendations

Recommendation 1:
Managers should ensure that a pathway is developed in partnership with social work colleagues to support a fully collaborative approach to discharge planning.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, record a clear plan of treatment and introduce an audit system to monitor this.

Recommendation 3:
Managers and the responsible medical officers must ensure individuals who lack capacity in relation to medical treatment have Section 47 certificates and where necessary, treatment plans completed in accordance with the AWI Code of Practice (3rd ed.), to cover all relevant medical treatment the individual is receiving.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also 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. This has been added to the action plan.

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.

Contact details

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

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk