Mental Welfare Commission for Scotland

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

Date of visit: 14 October 2024

Where we visited

Harlaw and Eden are acute assessment wards for people over the age of 65 with functional mental illness. The wards are based in the Royal Edinburgh Hospital and since 2018, have been housed in the Royal Edinburgh Building, a new part of the hospital with purpose-built units providing single en-suite accommodation for patients.

Harlaw is a ward for men, Eden is for women. While both are designed as 15-bedded wards, they have been operating with one additional 'contingency bed' for the past year and been over capacity with 16 patients.

We last visited this service in March 2022 on an announced visit and made recommendations on care planning, access to psychology, the recording of welfare proxies for those subject to the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) and the monitoring of discharge planning.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear from individuals, carers and from staff about their current experiences.

Who we met with

The visit team met with and reviewed the care of five people, all of whom we met with in person and reviewed the care notes of. No relatives asked to meet with us.

We spoke with the lead nurse, the senior charge nurses, and other members of the nursing teams.

Commission visitors

Dr Juliet Brock, medical officer

Denise McLellan, nursing officer

What people told us and what we found

Care, treatment, support, and participation

On the day of our visit, there were 16 people on each ward. We were told that bed pressures were worse than they had been on our previous visit, when this had already been an area of concern.

Both wards continued to have 'out of area' admissions, due to bed shortages elsewhere in NHS Lothian. Individuals with a diagnosis of dementia were also admitted when wards for those with this specific clinical need were full. On occasion, individuals were also transferred as 'boarders' from the acute adult wards when there were no adult beds available. Both Harlaw and Eden Wards had a waiting list at the time of our visit, with two people awaiting admission to each.

Throughout the visit we observed warm, positive interactions between staff and individuals and both wards had a calm, relaxed atmosphere.

Despite the challenges facing the wards, the feedback we received from individuals that we spoke with was very positive. We heard staff being described as helpful, supportive and that they were treated with respect. One person commented that staff "couldn't be kinder" and were "superb at managing issues".

A concern raised by staff, and also by one individual, was the use of contingency beds.

Multidisciplinary team (MDT)

In addition to medical and nursing staff, the multidisciplinary teams on both wards included input from occupational therapy (OT), activity co-ordinators, art and music therapy, with the recent addition of dramatherapy. Since our last visit, social workers had also been recruited to both wards and we heard that this had been a very positive addition to the teams.

We were told there was representation in weekly MDT meetings from the range of disciplines. There also continued to be input to the weekly MDT meeting from a hospital pharmacist.

Physiotherapy was available on referral, as was dietetic support.

The Rapid Response Team (RRT), based in the community, also continued to work closely with the MDT. This team supports discharge planning and helps to ensure continuity of care for individuals moving between hospital and the community.

We were advised there was still no clinical psychology input to the older people's functional service, despite this being a recommendation in the Commission's previous visit report. At the last visit, staff advised us that requests for psychology

input were made once patients were discharged; this was due to resource issues in the psychology department at the time.

The service responded to the Commission's previous recommendation indicating that senior managers in the hospital had agreed to the recruitment of two qualified clinical psychologists, in part-time posts. This was intended to provide dedicated psychology provision to Harlaw and Eden Wards and funding was allocated for this.

We found out on this visit that unfortunately recruitment to the posts had been unsuccessful at the time. Financial cuts in the intervening period had meant that funding for these posts was no longer available. The clinical lead for the older people's psychology service advised that alongside the directors of psychology, they continued to make a case to retain funding for these posts, but that this had not been successful to date.

On the visit, ward staff told us that the clinical psychologist working in the neighbouring dementia wards was able to provide some advice and support when needed. The inequity of clinical psychology provision across the older people's wards was however an ongoing concern, and we therefore repeat our previous recommendation.

Recommendation 1:
Hospital managers should address the inequities in access to clinical psychology across older people's services. Harlaw and Eden Wards should have the same access to psychology support as other older people's mental health wards.

The Commission requires the service to provide quarterly updates on action taken to address this issue.

The provision of senior medical support also remained challenging, with only one consultant psychiatrist covering the wards. There were experienced psychiatric specialty doctors providing support on both wards, in addition to a higher trainee who was in an acting up capacity as a consultant on Eden Ward. There was consultant input at weekly MDT meetings.

Physical health care was mainly provided by junior medical staff. There was also an advanced nurse practitioner (ANP) who was on a three-month rotation around the care of the older people's wards and whose main focus was in supporting physical health care. We heard from staff that this additional role had been beneficial.

We were pleased to hear on this visit that in general, staffing levels had much improved over the previous year. During our previous visit, we were aware that nursing staff vacancies had an impact on the clinical teams and we heard that nursing staff were exhausted. By the time of this visit, we heard about improvements in recruitment and retention levels, especially for trained nursing staff, and with the

addition of newly qualified nurses joining the teams both wards now had a full staffing quota. Staff morale also appeared much improved.

Care records
Clinical records were primarily held online on TRAKCare, the electronic record management system used in NHS Lothian. Some documents were still kept in paper files, such as do not attempt cardiopulmonary resuscitation (DNACPR) forms and legal paperwork, with copies of these mostly held online as well.

We found the daily recording in the care records to be multidisciplinary and generally of a good quality, including detailed reviews by medical staff, occupational therapy and other therapists. Daily entries provided by the nursing team varied in quality and the information provided was sometimes quite basic with limited detail, particularly in relation to an individual's participation in activities.

We noted that nursing staff were not using the 'canned text' prompts which some other teams had adopted and we would suggest that using these prompts could aid staff to reflect on various aspects of a person's care when completing their daily care records. Managers advised us that there were plans to introduce this when new mental health person-centred care plans were adopted by the service in early 2025.

We did see some evidence of nursing staff carrying out one-to-ones with individuals, though this was less evident in the files we reviewed for patients on Eden Ward. On Harlaw Ward, we noted that the recording of the one-to-ones we viewed were of a particularly high standard, and we were advised that Band 6 nurses were involved in this work.

Weekly MDT meetings were recorded using the local mental health structured ward round format. This included an attendance list, updates from across the disciplines, a summary of the MDT discussion and action points. We found these to be detailed, with good evidence of discussion by the consultant, with the individual, after the meeting.

Mental health risk assessments were available in the notes we reviewed and were often in place at the point of admission when people had been admitted via RRT. These were updated on admission by nursing staff and regularly reviewed. Again, in Harlaw Ward, we noted these were very detailed and of a high quality when Band 6 staff were involved in their completion.

Nursing care plans
On previous visits we have found nursing care plans to be variable in quality, not always person-centred; we have previously made recommendations for improvement.

On this visit, we were pleased to note evidence of some improvement. In the records we viewed on Harlaw, we found good examples of highly detailed person-centred care plans that were regularly reviewed, with evidence of careful reflection. The sample of care plans we viewed on Eden appeared more basic in detail and without clear evidence of regular review. We were advised that all care plans should be reviewed at least monthly.

We were told that senior charge nurses carry out regular care plan audits, reviewing two patient records every fortnight. Given the variability we found in the small sample of individual care plans we viewed on this visit, we would recommend a review of this.

Recommendation 2:
Managers should review the current audit process to promote improving and standardising practice across both wards.

We noted that there was ongoing work in relation to care plan recording on TRAKCare. The wards had been involved in recent pilots to develop new electronic person-centred care plans for mental health services across NHS Lothian and were awaiting the implementation of these. We heard that training was being provided to staff on the new care plan format; there was a member of the IT team on the wards, offering ad hoc support and training, to staff during our visit. We were told this was a regular occurrence and that the regular IT support was welcomed by the staff.

The Commission has published a good practice guide on care plans[1]. 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.

Use of mental health and incapacity legislation

On the day of this visit, eight men on Harlaw Ward and 10 women on Eden were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

On the last visit we had noted that it was not always clear if individuals were subject to the AWI Act and had a welfare proxy in place. We made a recommendation to managers about this to ensure staff had up-to-date information and that copies of the relevant documentation were held on file.

On this visit, relevant documentation relating to the Mental Health Act and the AWI Act was present in the files we reviewed. Where individuals had a welfare attorney, a copy of the Power of Attorney was on file.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2B) and certificates authorising treatment (T3B) under the Mental Health Act were in place where required and, in almost all cases, corresponded to the medication being prescribed. Where a prescribed medication had not been properly authorised, this was discussed on the day of the visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the 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. We found that where s47 certificates were in place, these were appropriately accompanied by treatment plans, however a few were missing key information, including confirmation of authorisation by the next of kin, and we advised that these were reviewed.

Rights and restrictions

Both wards were locked for patient safety and there was a locked door policy in place. We found notices on display explaining this to both individuals on the ward and visitors.

The hospital advocacy service, Advocard, continued to provide in-reach to both Harlaw and Eden. The individuals we spoke with had a good understanding of their rights and of the role of advocacy. Several people had active support from an advocacy worker and had also sought legal advice on several issues, such as appealing their detention to the Mental Health Tribunal.

We were pleased to see that there was a framed 'Patient Rights' board on display in the communal area on Harlaw Ward. We were told this had been put together by staff with the support of patients.

Where specified person restrictions were in place under the Mental Health Act, we found documentation in place but in one case an updated form needed to be completed by the responsible medical officer (RMO) to properly authorise this. 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 and where restrictions are introduced, it is important that the principle of least restriction is applied.

The Commission has produced good practice guidance on specified persons[2].

[2] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

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 asked about advance statements and a number of individuals we spoke with told us they knew about these and a few had an advance statement in place, either from a previous admission or from their contact with the community mental health team. From those we spoke with, and from the information reviewed on file, we did not find clear evidence that advance statements were being actively promoted on the wards. We raised this at the end of the visit as an area for potential improvement.

The Commission has developed *Rights in Mind.*[3] 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 on this visit of recent challenges with activity provision on Eden Ward, where there had been no full-time activity co-ordinator for a period due to maternity leave.

Although nursing staff were being allocated to support the OT assistant with activities, it was not possible to protect this time due to clinical activity across the hospital. It was acknowledged that this had been having a significant impact on those in the ward and this was reflected in the feedback we received on the day. We were assured by managers on the day that temporary cover for this post was being urgently sought.

On Harlaw, two part-time activity co-ordinators provided activity input from Monday to Friday. As well as facilitating group activities, activity co-ordinators also provided one-to-one support to individuals.

Occupational therapists mainly carried out assessments and together with OT assistants, had a rehabilitation focus and were involved in developing individual timetables.

Those that we spoke with on Harlaw Ward described a good range of activities taking place on the ward, including those organised by the activity co-ordinators, sessions from occupational therapy such as walking and cooking groups, as well as art, music and drama therapy. Feedback was generally very positive, and individuals

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

also told us about one-to-one sessions, such as going for a walk or going out for a haircut.

We also heard from those on Harlaw Ward about their access to activities in the hospital grounds, such as sessions at the Hive and the Cyrenians gardening project. One person told us about the support they received from the hospital's volunteer hub and how much they enjoyed their regular sessions at the hospital's library.

The physical environment

Both wards, which have the same general layout, are bright, well-lit and spacious; they continue to be maintained in good decorative order. Each ward had a housekeeper, and they kept the environment on both wards very clean.

The main, large communal spaces provided a comfortable lounge, with seating area for watching TV and an adjoining dining space. The furniture in these spaces appeared well looked after. In Harlaw, there was also a pool table, which was said to be well used by the men.

Both wards had additional seating areas around the corridors, looking onto the courtyard garden, as well as other communal spaces for people to spend time.

It was evident that more artworks had been introduced around both wards, providing colour and interest. Several artworks on display in Harlaw had been painted by a member of the MDT.

On Harlaw Ward we found printed photographic leaflets providing information about the ward for individuals and their families, which had been created by the senior charge nurse earlier in the year. Around the corridors were posters and leaflets with information for patients and families on display, in addition to a weekly activity timetable.

On Eden Ward there was less evidence of displayed information, however it was explained to us that posters and other materials had recently been removed by an individual who was in distress.

Adjacent to the main communal area on Harlaw there was a well-equipped group activity room, housing art and music supplies. There was also a therapy kitchen (shared with Eden Ward) which was reported to be well used by patients. Access was available through OT groups and at other times when ward staff/activity co-ordinators provided support in preparing snacks and simple meals. A group had recently been baking apple pies with fruit collected from the hospital's orchard.

There was a comfortable and pleasantly decorated quiet room on Harlaw Ward, furnished with a sofa, armchairs and equipped with books, puzzles, CDs, a TV and DVD's. This offered a calm and relaxing space for people to spend time away from

the main communal lounge if they wished. We were told this space was well used by individuals when they wanted to have time out on their own.

We asked where family visits took place; staff explained that where possible, families were encouraged to take their loved ones to the hospital café or for a walk in the grounds when visiting. For those unable to leave the ward, visits could take place in the main dining area or in the garden (in Harlaw, the quiet room was prioritised as an area solely for patient use).

The garden areas were well kept, providing clear pathways with open and covered seating areas as well as raised beds. The Cyrenians gardens project had helped with upkeep and planting and members of ward staff had also been involved in maintaining the space, with individuals on the ward supported to plant flowers and edible plants in the raised beds. We were told by both staff and patients that the outdoor spaces were well used and enjoyed.

Both wards have 15 en-suite bedrooms, arranged along three sides of a central courtyard. Most rooms had views out onto the grounds of the hospital. Bedrooms were clean and well maintained; they were able to be individualised with photographs and personal items. Each bedroom had en-suite shower facilities. The en-suites were designed with minimal ligature points, as were bedroom furnishings. Whilst the en-suite doors had an anti-ligature design, we were advised these were being replaced across the hospital, with plans for new doors with inbuilt alarms being installed.

The “contingency” bedroom in each ward had previously functioned as office space. Both rooms had been converted to a temporary bed space over a year ago and we were told they had been in continuous use as an additional (16th) bedroom since then. These rooms were not designed as bedrooms and had no en-suite facilities. Those who were allocated a contingency room had to use the communal toilet and showering facilities in the main corridor, affording them less privacy than their peers. We heard that several patients and their families had complained about this, as had the consultant psychiatrist.

We discussed this concern with managers on the day of the visit. It was explained that due to ongoing bed pressures across NHS Lothian, both wards were continuing to run at full capacity with the use these additional beds. We were advised that the matter had been escalated to senior executives in NHS Lothian and that short life working groups in the health and social care partnership (with representation from the inpatient and community services as well as those from social care) were regularly meeting to look at ways to manage the ongoing bed challenge.

It was confirmed that there were bed pressures across all hospital sites, with community services also stretched and managing a high level of risk. We were told

that this continued to be a whole-service issue that had an impact on the inpatient and community mental health services (in older adults and acute general adult care); the social care provision was also a significant factor.

Recommendation 3:
Managers should continue to review the need for - and use of - contingency beds.

The Commission is concerned by the ongoing use of this intended short term measure and requires details of how this matter will be addressed in the short to medium term. We also wish to be advised of the longer-term planning at health board level to address the increasing gap between service need and provision, particularly in light of the known challenges of the increasing and ageing local population.

Any other comments

As on previous visits, delayed discharges continued to be an issue, but we were told this was less of a problem. At the time of this visit there were two delayed discharges on Harlaw Ward and one on Eden. Most patients were discharged home, with or without a care support package.

We were told that the patients who were currently delayed were awaiting discharge to specialised units, with two waiting for a place at Ellen's Glen, a hospital-based complex clinical care (HBCCC) unit in Edinburgh for adults over 65 with a functional mental illness. We were advised that the unit currently has a waiting list of 12-18 months.

There was a weekly older people's bed management meeting, chaired by the Band 8 manager, with the hospital's delayed discharge manager and staff representation from all wards.

We were also advised that to help with the management of the waiting and admission planning, there was now a daily 10am bed meeting attended by the clinical nurse manager**,** a charge nurse from each older people's ward and representation from RRT. This meeting, which was started in August 2022 and is well established was said to have been helpful in managing the waiting list.

Summary of recommendations

Recommendation 1:
Hospital managers should address the inequities in access to clinical psychology across older people's services. Harlaw and Eden Wards should have the same access to psychology support as other older people's mental health wards.

Recommendation 2:
Managers should review the current audit process to promote improving and standardising practice across both wards.

Recommendation 3:
Managers should continue to review the need for - and use of - contingency beds.

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.

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