Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Edinburgh Hospital, Fairmile and Canaan Wards, Morningside Terrace, Edinburgh EH10 5HF

Date of visit: 3 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Canaan and Fairmile Wards are dementia assessment and treatment wards for older adults in Edinburgh. The wards have been based in purpose-built facilities in the new Royal Edinburgh Hospital since 2017. Canaan is a male ward and Fairmile is a female ward. Both were designed with 15 bedrooms and provide single en-suite facilities throughout and on the day of our visit, there were 16 people on Canaan Ward and 15 in Fairmile Ward.

The service had an announced visit in January 2023 and made four recommendations, including the need to improve the quality of information recorded in the daily entries to ensure it provided a meaningful narrative on an individual's difficulties, progress, and recovery and also to develop a regular audit of the care plans to ensure quality. Other recommendations made during this visit were around having a clear and accessible locked door policy, to improve recording of activities in individual's records, and where there were section 47 certificates completed under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) in place, accompanying treatment plans should be available to cover all relevant medical treatment that the individual was receiving.

During this announced visit we wanted to speak with individuals, relatives, and staff and we were keen to find out how the service was implementing the recommendations from the last visit to the service.

At the time of this visit, we were informed that both wards had a small lounge area that had been designated as a bedroom, to allow for another admission on each ward, when required. We were concerned that this did not offer a satisfactory or equitable alternative as there were no toilet or bathing facilities in either of these areas. This also took away a quiet area in each ward which could impact on those who preferred a quieter space. We were also made aware that at times, Fairmile Ward was used to board individuals from acute wards. We informed that this was not best practice and asked if there was a long-term plan to avoid this. We were not advised of any plans to address these concerns or cease these practices.

Who we met with

On our visit we met with eight individuals on the ward and spoke with four relatives. We reviewed the care records of seven people, some of those we met and others who were residing in the ward.

We spoke with the senior charge nurses (SCNs), the depute charge nurse, the activity co-ordinator, other nursing staff and medical staff.

Commission visitors

Sandra Rae, social work officer

Anne Buchanan, nursing officer

Gordon Mc Nelis, nursing officer

What people told us and what we found

During our visit we gathered feedback from individuals and relatives in relation to their care and treatment and experience in both wards.

The feedback we received from carers from individuals was mostly positive. One person in Canaan Ward told us “everyone cares for you, you can always ask someone a question if you are worried, and they will help answer it” while another person remarked “the staff are great.” We also heard that for some people in Canaan getting of the ward with the activity co-ordinator “was excellent” and it was “nice to go to the HIVE (a local community space in the hospital for activities) with others.” Another person told us “the place, could not be improved upon it is great!” One patient did mention that the nursing staff were remarkably busy, and they did not like to bother them and cause extra work.

The individuals in Fairmile Ward were less positive and felt the activities were either not what they wanted or not enough. We heard that one person “enjoyed going to gym and meeting other people.” One person in Fairmile Ward did not feel her relationship with staff was as positive as it had been when she was first admitted. For someone who did not wish to be in Fairmile Ward they found the staff welcoming but “overpowering when they observe you all the time.”

People in both wards described the food as excellent and everyone we spoke to told us they liked having their own room, and bathroom.

We met with family members from Canaan Ward and offered to contact relatives from Fairmile Ward if they wished to speak with us as no one was available on the day of our visit. However, no relatives made contact.

A family member from Canaan Ward told us that the environment and the space in each bedroom “was excellent.” They also informed us that staff took time to get to know the person and respected their wishes. Relatives described Canaan staff as “excellent and better than in any care home” and another described the staff as “brilliant.” Families and welfare guardians we spoke with said there was excellent communication from the clinical team, and they felt involved and consulted in their relative’s care. They also said there was good availability of medical staff and thorough monitoring and provision of physical health care.

One family member who had a relative in Canaan Ward informed us that their experience was not as positive as it could have been, and communication was poor. They were not informed by the ward that when their family member had to go to the general hospital for treatment, their bed would not be kept for them to return to. They found this upsetting in an already stressful situation, and to be told by others that the bed was not available for the person to return to left them feeling hopeless. This had been addressed by ward staff, and it was recognised that there was learning to be had to ensure that staff are more explicit in discussing these scenarios when a person is admitted to the ward.

Another family member came into Canaan Ward to see the Commission, although their relative moved the week prior to the visit. The relative informed us that at their time of need and exhaustion caring for a family member the staff were “like angels” and “immediately they took the stress and worry away” they had experienced caring for the relative in the community. We were informed that the relative was kept fully involved and supported with making complex decisions. They also told us that if there had been a choice, their relative would have lived in Canaan Ward. The relative was clear that their family member had now settled in a care home due to the care, dedication, communication and supported transition from staff on Canaan Ward.

We met with the activity co-ordinator from Canaan who provided us with an in-depth insight into their role and the activities they supported people to take part in, both in the ward and in the local community. They had just returned with some people who had been at a local group at the football ground which was great for reminiscence work. The activity co-ordinator also discussed the activities that took place in the ward such as artwork, quizzes, and organised singsongs. They spoke of supporting people to the HIVE. We were pleased to hear they also had a weekly budget of £30 for activities and equipment. We heard that families were very generous at financially supporting any activities off the ward that would benefit their relative.

We heard from families and individuals on the ward that the occupational therapy (OT) and nursing staff also provided meaningful activities when the activity co-ordinator was not on duty.

Care, treatment, support, and participation

Care records

In both wards all individual care records and care plans were stored on the electronic record information system, TrakCare. Some documentation, which was required for administering medical treatment was stored in paper records in the treatment rooms of both wards.

We found TrakCare easy to navigate and most of the continuation notes were informative and linked to care plans that were written to meet the physical health

and mental wellbeing of individuals. We saw evidence of OT support, with detailed assessment and recording of input, and the same for psychology input, with excellent individual psychological formulations in care records.

Individual records evidenced multidisciplinary discussions with family members, where appropriate. We saw evidence of conversations with relatives, power of attorneys and welfare guardians. In the care records, we also saw one-to-one conversations between individuals and staff.

We found 'do not attempt cardiopulmonary resuscitation' (DNACPR), section 47 certificates, and other legal paperwork in care records. We saw one DNACPR certificate in Canaan Ward where a person had initially decided they did not wish resuscitation, however, their situation improved, and they changed their mind and wished to be resuscitated if this became necessary during their hospital stay. The file had not been updated to reflect the change. We discussed this with the SCN on the day of the visit.

Recommendation 1:
Managers should ensure that the current audit process includes the auditing of all DNACPR paperwork to ensure that all DNACPR decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every individual on the ward.

Care plans
We saw examples of robust care plans in both wards that provided a person-centred account of individual needs and subsequent interventions. We found these linked with the information that was gathered from admission.

There was evidence of care plans being regularly reviewed in both wards. We also saw evidence of engagement with the individual and wider family where relevant, in relation to care plans and heard of individuals being offered a copy of their care plan.

We were pleased to find the content of care plans gave the reader a good account of the individual's current and historical needs, which was helpful for staff who may not be familiar with an individual, or aware of their presentation or circumstances. We found detailed and person-specific care plans in place for each person in both wards relating to mental health and physical health which demonstrated an awareness of the link between the two.

In all of the files we reviewed, we found that involvement and participation had been recorded during care plan reviews in continuation notes or documented as a one-to-one meeting in the person's file.

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. It is helpful for all staff to continue to consider this document in all care planning ensuring ongoing best practice for all staff completing care plans.

Risk assessments
We saw risk assessments on both wards that were detailed and provided good historical information; and where appropriate, there were excellent psychology risk formulation plans to support the individuals on the wards. The risk assessments were reviewed regularly.

We saw an example of innovative stress and distress formulation work that had taken place in Fairmile Ward facilitated by psychology, including an art therapist, input and OT. This evidenced the work required to assist one individual have a clear plan tailored to their individual needs. This process allowed the MDT and staff caring for the person to make sense of the person's difficulties and identified individualised measures to support them.

Discharge planning
There were three people who were delayed discharge in Canaan Ward and four people in Fairmile Ward when we visited. There was a robust approach to discharge planning, with senior ward staff actively involved and a social worker attached to both wards. However, there was a vacant social work post that remained unfilled to support Fairmile Ward during our visit, although it has been advertised. This could impact on delayed discharges if this remains unfilled in the longer term.

We heard from the relatives that we spoke with that they felt it was a key strength of Canaan Ward in that they were fully included and consulted as part of the discharge planning process with their family member. We also heard that this approach was mirrored in Fairmile Ward.

Multidisciplinary team (MDT)
We found that each ward had input from a wide range of professionals who contributed to individuals care and treatment and the MDT met weekly. The MDT meeting records were well presented, and it was clear to see who attended and who had responsibility for the defined actions.

The care and treatment of the individual was reviewed at each meeting, progress summarised, and the care plan updated. We were told that there was one consultant psychiatrist who covered the two wards, and that the MDT also consisted of speciality doctors in both wards, clinical psychology, nursing staff, social work, OT,

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

music therapist and an activity co-ordinator in each ward. There was also input from pharmacy at the MDT meeting.

We heard that individuals had regular access to other allied health professionals, such as speech and language, dietetics and physiotherapy as required. We were informed by families that they had meetings out with the MDT, with relevant others, in relation to the care of their relative.

We heard that meetings took place when it was time to plan for discharge or if further interventions were required. We heard that the SCNs and charge nurse were often in touch to gather the views of the family or power of attorneys on the care of their relative and update them on the outcome of the MDT. The families we spoke with were of the view this was the most appropriate use of everyone's time, and they would find it daunting coming to a full MDT meeting.

Use of mental health and incapacity legislation

On the day of our visit, 11 individuals in Canaan Ward and 10 individuals in Fairmile Ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). We found all the documentation that related to the individual's legal status was in order and easily accessible in both wards.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. All documentation relating to the Mental Health Act and the the AWI Act, including consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place in both wards where required and corresponded with the medication being prescribed. Paper copies were stored in the treatment room, to allow for easy access when dispensing medication.

For individuals who had a legal proxy appointed under the AWI Act, we saw copies of the legal order in place in both wards.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate, along with accompanying treatment plan under s47 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, who has relevant powers and record this on the form. There had been a recommendation made following our last visit in relation to s47 certificates and the need for a treatment plan to cover all relevant medical treatment to be included with them. We were pleased to see all s47 certificates that we reviewed had a treatment plan and evidenced a discussion had taken place with family or legal proxies. Two of the s47 certificates we looked at in Fairmile Ward required updating as they had just become out of date. This was

completed by the appropriate medical staff member during our visit, after we brought it to the attention of the nursing team.

Rights and restrictions

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. In the wards, we did not find any named persons in place. We discussed this with staff who informed us that often when a person was detained under the Mental Health Act, they were not well enough to nominate a named person, however, this was discussed at the time of detention by the responsible medical officer (RMO).

Both wards had a locked door policy displayed both on the outside and the inside of their main doors. We were informed that some individuals, who due to their vulnerability and progression of their illness, would be at risk if the door were opened.

Where individuals had been detained under the Mental Health Act, we found that they had been provided with information about their rights and had access to advocacy services. This was not the same for individuals who were informal, and they were less able to recall and discuss their rights during their hospital stay due to the progression of their illness and ability to retain information.

When we review individuals' 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 did not find any advance statements in either Canaan or Fairmile Wards.

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.

Activity and occupation

Each ward had a full-time activity co-ordinator who provided activities on a one-to-one or group basis. We were pleased to hear that there was a small budget set aside for the activity co-ordinators to use each week. This clearly enhanced opportunities for those in the wards and allowed more activity out with the ward environment.

Individuals from both wards told us they enjoyed their time out of the ward with the activity co-ordinator. We were able to see from the board on the wall the activities

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

that were taking place on both wards. We were informed of others who supported activity in Canaan and Fairmile. Activities included pet therapy, and music groups that come regularly to both wards. There is also music therapy which delivers provides is a form of psychological therapy and is provided by the Arts Psychotherapies Service

The activity rooms were well stocked with art materials and various other equipment to allow both groups and individuals to enjoy the activity. We saw lots of examples of what was available on the day of our visit. In Canaan, a few of the men attended the local football club in the morning and others used the activity room. In Fairmile, there was evidence of artwork and individual pampering sessions with a music band who attended the ward in the afternoon. We saw the enjoyment this gave the individuals in both wards.

We found some evidence of activities that individuals took part in were documented but felt that the therapeutic support and benefit could have been more robustly recorded and linked to care planning, as well as a record if the activity had been offered and refused.

Recommendation 2:
Managers should ensure that all activities are recorded and linked to individual care plans, with a record of any benefit of the activity to the individual, as well as non-engagement.

The physical environment

Both Fairmile and Canaan Wards were very well maintained, clean and had space for purposeful walking for individuals in the ward.

All the rooms were single, with ensuite facilities and very well presented. We were told that a section of one bedroom corridor on Fairmile Ward could also be 'locked off' for use by individuals on the adjoining Canaan Ward if required, enabling four 'swing beds' to be transferred for male use if needed.

There were whiteboards in the bedrooms which detailed 'what was important to me' and allowed staff entering the room to see this important information at a glance. There were small open wardrobes for people to store clothes which was satisfactory for those we spoke with as it had been mentioned in the last visit report about the lack of space for belongings.

There was ample space for dining and larger activities in the lounge areas of both wards.

There was a lack of quiet spaces as a small lounge in both wards had been repurposed. We heard this affected some of the therapeutic work, as the activity room was being used as more of a multi-purpose room rather than a designated

activity room. It also prevented people watching the television in a quiet space and helped to alleviate sensory overload.

We heard from people and carers that we spoke with that the garden areas were pleasant. We found these areas in both wards to be well kept, with raised beds and an area to walk around.

Good practice

We were informed of an area of good practice that had been rolled out in Canaan Ward with the introduction of an advanced nurse practitioner (ANP) post.

The ANP had made a significant difference in supporting training for staff in all aspects of dementia. Clinical psychology also had a training role with staff in stress and distress education this area. The ANP had provided training and development for staff in Canaan Ward around physical health and was in the process of moving to other older people wards across the hospital to continue the learning and development for staff teams.

The SCN in Canaan had commented what a positive impact this has had for their staff. The SCN in Fairmile informed us that they were looking forward to this training and development opportunity for the staff too.

Summary of recommendations

Recommendation 1:
Managers should ensure that the current audit process includes the auditing of all DNACPR paperwork to ensure that all DNACPR decisions are reviewed and there is a consistent system to ensure that all staff members are aware of the DNACPR status of every individual on the ward.

Recommendation 2:
Managers should ensure that all activities are recorded and linked to individual care plans, with a record of any benefit of the activity to the individual, as well as non-engagement.

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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