Mental Welfare Commission for Scotland

Report on announced visit to: The Orchard Clinic, Royal Edinburgh Hospital, Edinburgh EH10 5HF

Dates of visit:
Redwood Ward – 19 August 2024
Cedar Ward – 20 August 2024
Hawthorn Ward – 2 September 2024

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

The Orchard Clinic is a 40-bedded, medium secure forensic unit on the Royal Edinburgh Hospital site. It has three wards: Redwood, a 15-bedded, mixed-sex acute admission ward and two forensic rehabilitation wards; Cedar a 14-bedded rehabilitation ward for men and Hawthorn, a mixed-sex, 11-bedded rehabilitation ward.

In recent years we visited, and reported on, the acute and rehabilitation wards separately. We last visited Redwood Ward in August 2023, and our last visits to Cedar and Hawthorn Wards were in October 2023. All were announced visits.

We made no recommendations to Redwood Ward at that time. We made four recommendations to Cedar and Hawthorn Wards in respect of improving physical health monitoring, auditing nursing care plans, improving access to physical activity and to the outdoor environment. We received an action plan addressing all four areas.

On this occasion, we took the decision to combine the visits, to provide an overview of the whole service and to offer feedback to managers for all three wards. We wanted to follow up on previous recommendations, to hear people's experiences of their care and treatment and to speak to staff.

The visits to the three wards were planned over two consecutive days. However, due to unforeseen circumstances, the visit to Hawthorn Ward was postponed at the request of the service. Instead, we carried out this third visit several weeks later.

When we last visited Redwood Ward, bed numbers had been reduced from 15 to eight in preparation for renovation works to start on the unit. On this visit, bed numbers remained at eight, with the ward full and works due to commence.

Who we met with

In Redwood Ward, we met with six of the eight individuals on the ward and reviewed the care records of seven. In Cedar Ward, we met with six people in person and reviewed the care records of seven. On Hawthorn Ward we met with six individuals, three of whom we also reviewed the care records of.

No relatives requested to meet with us on these visits.

We spoke with the clinical nurse manager, the medical director, the senior charge nurses, the consultant psychiatrists, the peer support worker and other members of the ward teams.

We also met with members of the senior leadership team when we gave feedback at the end of each of the three visits.

Commission visitors

Juliet Brock, medical officer

Lesley Paterson, senior manager (practitioners)

Anne Buchanan, nursing officer

Gordon McNelis, nursing officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Care, treatment, support, and participation

The individuals who spoke with us on these visits to the Orchard Clinic were generally positive about their experiences of care.

In Redwood Ward, people spoke of the staff being supportive and of feeling safe on the ward. This included two females who were receiving care on the ward at the time of our visit. No concerns were reported to us. Individuals felt involved in decisions about their care and treatment, they knew who their keyworkers were and spoke of participation in their weekly clinical team meeting (CTM).

On Cedar Ward, on this visit the feedback we received was slightly more mixed. We heard some positive comments, with individual feedback providing praise for the work of the nurse therapist and of feeling listened to by consultant psychiatrists. However, a few individuals on Cedar Ward raised concerns about a small group of staff members who they felt had negative attitudes towards some people in their care. One individual complained about staff smoking on escorted passes, when they themselves were not permitted to smoke. We discussed these concerns with senior managers at the end of the visit.

On Hawthorn Ward, the people we met with spoke positively about staff, describing them as “approachable” and “supportive”. Individuals also spoke of feeling safe on the ward, including the sole female receiving care there at the time of our visit. Positive peer relationships was also something highlighted by those we met with on Hawthorn Ward. Some of those we met with also spoke positively about participation in clinical team meetings (CTMs) and told us they felt involved in decision-making about their care.

Multidisciplinary team (MDT)

All wards continued to be supported by multidisciplinary teams of professionals based in the clinic. In Redwood Ward, CTMs took place on a weekly basis, with one meeting for each of the five consultant teams. In the rehabilitation wards, CTMs continued on a fortnightly basis, each ward holding two meetings per week.

In addition to medical and nursing staff, the wards had input from occupational therapy (OT) and psychology, along with art psychotherapists and music therapists. Social workers remained based in the clinic, providing support to clinical teams, and the peer support worker continued to provide input to individuals across all three wards. The clinical pharmacist also had ongoing input across all wards and attended MDT meetings.

Each of the MDTs had a consultant psychiatrist and representation from professionals across the above disciplines. In-reach from other professionals, such as dietetics and physiotherapy, remained available on referral.

Previously, a visiting GP had been attached to the clinic and had carried out surgeries on a regular basis. During our last two visits, this GP post had been unfilled, and we were concerned at the impact that this had on access to routine physical healthcare, particularly for those on the rehabilitation wards, who may have been in hospital for a number of years.

For the individuals in Cedar and Hawthorn Wards, physical health monitoring (including routine screening) is particularly important. We made a recommendation following the last visit to these wards that managers should ensure a robust system was in place to monitor the physical health of individuals in the clinic, with annual health checks where applicable. We advised that health monitoring should be clearly recorded in individual records.

We were pleased to learn on these visits that a new GP was now in post and surgeries were again taking place in the clinic on a regular basis. We saw evidence of this in the records we reviewed.

Staffing

When we last visited Redwood Ward, the staff team had been significantly depleted. At that time, eight staff were on extended leave. On the latest visit we were pleased to learn that the nursing team was back to full complement. This had followed a reduction in sickness absence and a period of recruitment, with four new nurses having taken up post. We were told that staff morale had also improved.

We were advised that the OT provision had significantly reduced, with two full-time OTs having recently left the service at the time of our visits. We have since been advised that successful recruitment has meant that OT provision has improved.

Care records

Individual care records were mainly held on TRAKCare, the electronic health record management system used by NHS Lothian. We were pleased to see that limited information was now held on paper files and on the clinic's shared drive, as this had been a risk issue highlighted with managers on previous visits.

In the paper files we viewed, we mainly found copies of last care programme approach (CPA) documents and copies of mental health paperwork, which we were told were used for reference. We noted that copies of these documents were also available in the electronic records.

In the individual records we viewed on TRAKCare, we generally found a good level of detail in the daily clinical recording.

We noticed for the first time that canned text was being used by some staff. This introduced pre-populated headings to each care entry, prompting staff to comment on specific aspects of a person's care. This appeared to us to have led to further

improvements in documentation, such as in the recording of activities e.g. what activities were being offered and a note of the individual's participation, or refusal.

We noticed some disparity between wards, with canned text only being used by staff in Redwood Ward; this had not yet been implemented in the other wards.

We noted good recording of one-to-one meetings with individuals by staff on all three wards, which appeared to be happening at least once a week. These interventions were not always being labelled as one-to-ones, so were not always easy to find.

On Redwood Ward, we heard that two newly qualified staff were carrying out a quality improvement project on one-to-ones, working on improving these and using canned text as heading prompts. We welcome this initiative and look forward to hearing about the outcome on our next visit.

The involvement of a range of professionals from the MDT was clearly evidenced in the care records, with detailed entries recorded by OT, psychiatry, psychology and art psychotherapy. We found the notes of the latter to be particularly person-centred and strength based.

When we looked at records of CTM meetings, a record of attendance was not always provided. Nursing updates were comprehensive, however, we found that multidisciplinary input into the CTM discussion was not always evidenced. In some cases, there was a record of individuals attending their CTM meeting (or, if not, of their views being sought), but in others individual engagement and participation was unclear. The recording of agreed action plans was also variable.

We were told that CTM records were usually typed by the junior member of the medical team during the meeting. We discussed whether there was an opportunity to offer guidance and support to junior staff (e.g. on key information to include in the CTM record) to help achieve better consistency across clinical notes in the future.

We found evidence of regular medical reviews and of three to six monthly care programme approach (CPA) meetings in individuals' records. CPA is a framework used to plan and co-ordinate mental health care and treatment and there is involvement of a range of different professionals, with the aim of keeping the individual and their recovery at the centre of this approach. For certain groups of people, enhanced CPA can be used as a mechanism for regular review of their care, treatment, needs and risk management.

CPA records were saved on TRAKCare, rather than in the clinic shared drive and as noted previously, were comprehensively documented.

We found good documentation in relation to physical health, with lots of references to physical health issues being reviewed and referrals for further investigation and consultation when required.

Care plans
It was evident on all three wards that the staff had very detailed knowledge of individuals in their care, and especially of their challenges and support needs. Unfortunately, this information was not always reflected in the care plans we viewed

Again, we found some variation in practice between wards.

In Redwood Ward, the care plans we viewed were quite detailed, especially when they involved the care of individuals being nursed in the high dependency suites, for whom seclusion and higher levels of restriction were in place. We found many care plans to be positive and person-centred, with evidence of individual participation. A care plan audit was underway on the ward and staff were in the process of changing care plans at time of our visit.

In Cedar Ward, the care plans we viewed were of poorer in quality, in comparison to Redwood. We found the interventions in care plans lacked detail and did not reflect the wealth of information in CPA documentation or risk assessments. Reviews were also basic, and we found some care plans that had not changed in several years. Only a few evidenced participation of the individual in the care planning process.

Similarly, on Hawthorn Ward we found the standard of the care plans that we viewed failed to reflect the knowledge staff had about individuals in their care and the personalised way they were supporting recovery. Again, individual care plans lacked detail and meaningful review. We also saw examples where content appeared to have been cut and pasted from generic documents.

Recommendation 1:
We repeat our previous recommendations that managers should ensure that care plans are regularly audited to ensure these are person-centred, that reviews fully reflect individual's progress towards stated care goals and that recording is consistent across all care plans.

We were told that improvement work for care plans was continuing. The action plan received following the previous visit to the rehabilitation wards had advised that a short life working group had been set up to investigate care plans and audit tools.

A new addition to TRAKCare of person-centred care plans specifically designed for individuals receiving mental health care, was in development. We were told there were plans to audit new care plans daily once this was in place. We have recently been informed that new person-centred care plans are being implemented across

the clinic and that regular audits are underway. We look forward to seeing progress in this area of future visits.

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

All individuals in the clinic were detained under the Criminal Procedure (Scotland) Act,1995 (Criminal Procedure Act) or the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

All documentation relating to the Criminal Procedure Act and the Mental Health Act was in place in the electronic records in the records that we reviewed; the people we met with had a good understanding of their detained status.

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 found 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.

Rights and restrictions

As a medium secure unit, the Orchard Clinic is a locked environment. Staff in the reception area permit entry and exit to all individuals, staff and to visitors to the unit. Each person had details about their level of authorised passes documented in their care records.

Advocard, the hospital-based advocacy service, continued to provide independent advocacy support to individuals across the clinic. This was mainly via pre-arranged one-to-one visits, as well as drop-in sessions.

Collective advocacy was arranged via the Patient's Council. Wards reported that drop-in sessions for this group advocacy were not always taking place monthly, as they had done in the past.

When we spoke with individuals on all three wards, we noted there was improved awareness of rights-based issues. We also noted references in clinical records to people being offered advocacy support. When we discussed this with staff, they explained that a new programme of low intensity psychological interventions (LIPI) was being offered by an assistant psychologist. In addition to providing a recovery

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

focus, these sessions included topics relating to individual rights and the Mental Health Act, including the role of independent advocacy, the right to legal representation, named persons and advance statements.

We also noticed references in case records for people being offered advocacy support, and of advance statements being discussed. This initiative was welcomed by individuals and the staff that we spoke with, and we reflected the positive feedback about this rights-based approach to the senior managers at meetings after visits.

We asked about collective forums on the wards for people to provide general feedback about their inpatient experiences. On Redwood Ward, we were told that feedback was mainly sought on an individual basis, with ward community meetings – facilitated by staff - held on an ad-hoc basis. We discussed this with senior managers at the feedback sessions and were told that this was an area of development that was under discussion across the clinic.

We also asked about support for carers. There had previously been a carer support group run by the clinic, although this had not been running since the start of the Covid-19 pandemic. It was encouraging to hear that this was an area under review. We were advised that a number of staff were undergoing training to be carer champions, with the aim of re-establishing a carer group.

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

We received mixed feedback about activity provision in the clinic on this visit. Individuals in the rehabilitation wards described more positive experiences, as had been the case previously.

In Redwood Ward, some people said there was plenty to do, though not all agreed. One person told us that there "wasn't enough time in the day" to access all that was on offer. In contrast, another person, who was receiving care in one of the high dependency units (HDUs) at the time of the visit, told us there was "nothing to do on the ward" and that staff shortages had an impact on activities.

For those individuals who were able to have time out of the ward, they could access the OT programme provided on Cypress (in the clinic). Those whose pass extended out with the clinic also had access to activities across the hospital site, and sometimes in the local community.

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

In Redwood Ward, there was a weekly music therapy session and a weekly art group. Some individuals also had one-to-one art psychotherapy. A few people told us that they used the gym on the ward. Others mentioned helping with gardening tasks in the ward garden. Although OT in-reach to Redwood Ward was reduced at the time of the visit, ward staff were also making efforts to provide informal activities for those restricted to the ward environment. These included recreational activities such as quizzes. Those able to leave the ward spoke positively of accessing the OT programme in Cypress.

We found evidence in the clinical records that people had been asked about their individual likes/dislikes in relation to activities. We also noted good recording in the clinical notes in relation to activities, including references to staff approaching individuals more than once to offer activities when a person was struggling to engage, or needed encouragement to participate.

For those receiving care on the rehabilitation wards, Cedar and Hawthorn Wards, the feedback on activities remained more positive, as had been the case in the past.

Those we met with spoke about having lots of opportunities to engage in a variety of therapeutic, educational and recreational activities both in the clinic, across the hospital site and in the wider community.

The only negative feedback we received from individuals on Cedar and Hawthorn Wards in relation to activities was the availability of staff to accompany those who required escorted passes. When activities and passes were staff-dependent, we were told that sometimes these could not take place when the wards were short staffed. One person said they were reluctant to ask for staff support in the community when they felt they needed this, because of an awareness of limited staff capacity.

We heard from the staff teams on the visits that there were plans to employ an activity co-ordinator for each of the three wards. Senior managers confirmed that a proposal had been accepted with funding approved for this initiative. This is a welcome development, particularly at a time when OT resources have been more stretched across the clinic.

We look forward to seeing how the introduction of activity co-ordinators impacts people’s experiences on future visits.

The physical environment

The general environment around the clinic was clean, bright and in a good state of repair, with many areas appearing freshly painted.

On previous visits we had raised issues with general maintenance around the clinic. Following this, regular meetings had been established between clinic managers and

the hospital estates department to identify and address any ongoing issues. Overall, we noted improvements as a result of this, although a few upkeep issues remained, with window cleaning something that still could have been better, something a few individuals also commented on when we asked them about the environment.

In Redwood Ward, the main communal lounge was bright, and the furniture appeared new. The dining room, a space also used for group activities and for relatives to visit, was a light and pleasant environment. The corridor had been upgraded with new flooring which gave the environment a brighter appearance. There was information and a notice board with a weekly timetable in the corridor space. The additional activities room provided a further small sitting room with TV, DVDs and games. The separate female sitting room, which we were told continued to be well used by females on the ward, was a comfortably furnished space with two small sofas, books and DVDs.

We were pleased to note that the fitness room on Redwood Ward (which had been unusable at times in the past due to broken equipment), continued to be well used, with a running machine, cycling machine and yoga mat. This provided opportunity for supervised exercise for those restricted to the ward environment, who were unable to access either the gym in Cypress, or the physiotherapy gym in the main hospital building.

Bedrooms on Redwood Ward were set across three corridors, with a high dependency suite at the end of each. The first phase of renovations to upgrade all en-suite shower rooms across the clinic had been planned for many years. Work was due to get underway in Redwood when we visited the ward in 2023. On this visit, we found that the contractors had commenced refurbishment of en-suites in the first corridor. This work was due to continue across the clinic, corridor by corridor, across each of the wards. A detailed plan had been put in place to logistically enable this work while continuing to enable all three wards to function, with the reduced bed capacity.

In Cedar and Hawthorn Wards, the general environment had also benefitted from a refresh, with walls repainted and new flooring installed in some areas. We were pleased to note that there was new furniture in the communal lounge in Cedar Ward, after individuals and staff commented on the poor state of repair of furnishings when we last visited. On Hawthorn Ward, people continued to benefit from two lounges, offering social space and equipment for activities that had been requested at ward community meetings. An additional quiet room provided a restful space when this was required. The female sitting room also continued to be a well-used and welcome space for the women on the ward.

On both rehabilitation wards, we noted the positive visual references to recovery, with a “what matters to you” wall on Cedar Ward which those on the ward had helped

to create, as well as recovery and health information that was on display on the noticeboard in Hawthorn Ward. Timetables and information on activities was also available on the wards.

A large dining room space adjoining the wards was used for mealtimes and to support visits. Off the ward, there was a shared utility room, where people could do their own laundry.

Both wards had two bedroom corridors. Unfortunately, there were issues with newly fitted doors to one of the corridors on Cedar Ward, where repairs were awaited.

People were able to personalise their bedrooms and the rooms we saw were clean and in a good state of repair. In contrast, the en-suite shower rooms remained tired, uninviting and were awaiting the planned upgrades. Mouldy shower curtains were again noted in some areas, a recurrent issue which needs to be addressed promptly. We also noted issues with some shared facilities, with the shower room on Hawthorn Ward having mould on panels (despite previous repairs) and again the shower curtain needed replacing. We discussed these easily resolved issues with senior staff during the visits.

Outdoor spaces in the Orchard Clinic generally remained poor in comparison with those accessible to people in newer parts of the hospital.

In Redwood Ward some improvements had been made to the garden space since we last visited, with flower beds cleared and new planting by staff and individuals, as well as wooden seating that had been repaired and painted. It was recognised that this was an ongoing project, with further improvements still required. The senior charge nurse had made an application for a charity grant to fund this and we were told that discussions were taking place with a greenspace project to look further at optimising the outdoor environment.

Less progress had been made in respect of the shared garden space accessed by those on Cedar and Hawthorn Wards, which was in a very poor state of repair. Uneven paving slabs in the outdoor area were a concerning trip hazard and the wooden outdoor seating was shabby and falling apart. Although the space remained well used by those on the ward, it was far from inviting. Disappointingly, the outdoor basketball court has remained out of use for a further year, despite the Commission repeatedly raising this as an issue that was in need of attention in recent years. This is a missed opportunity, given the space was previously well used and enjoyed, having provided an accessible outdoor space for sport and recreation. The issue remained one of contracting for the required cleaning of the hard surface, which had grown moss over the last few years and was unsafe to use in its present state.

In our last report after visiting the rehabilitation wards, we recommended that “managers should work with the estates department to prioritise the improvement of

outdoor areas in the Orchard Clinic, so that these offered safe, accessible and welcoming garden and recreational spaces for patients to use and enjoy."

We discussed the lack of significant progress with senior managers on these visits. We were advised that senior managers were aiming to work with colleagues in Edinburgh Health and Social Care Partnership (HSCP) with a view to linking in with council contracts for similar works. There was also a plan to collaborate with a project at HMP Edinburgh where refurbished tools were used to make and repair furniture.

While these plans were welcomed, the slow progress in this area and the lack of equity for those receiving care in the clinic, particularly given the increased levels of restriction that many are subject to, remained disappointing.

We have been advised recently that, after significant investment, the outdoor basketball court had been upgraded with an all-weather surface and was now back in use. We were pleased to hear this had been in continual use since being reopened and that people were enjoying using it for a wide range of outdoor activities. We look forward seeing this when we next visit and to the ongoing improvement of the outdoor environment across the clinic.

Recommendation 2:
Managers should continue to work with the estates department to prioritise the improvement of outdoor areas in the Orchard Clinic, so that these offer safe, accessible and welcoming garden and recreational spaces for people to use and enjoy.

With respect to staff areas, a recent change had been made to introduce office space for charge nurses on the wards. We were told this initiative was to support more senior staff presence on the wards, rather than office space being designated solely in non-clinical areas elsewhere in the building. In the main corridor we were also shown a newly created wellbeing room for staff, shared between the three wards. This offered a space for staff breaks away from the clinical areas.

Any other comments

When we carried out visits in 2023, eight people were awaiting admission to the clinic, with no beds available. At the time of these visits, the waiting list had reduced to three, with two individuals waiting for transfer from prison settings and one person awaiting transfer from the State Hospital to a lower level of secure care.

We heard feedback from individuals and from a number of staff that for individuals subject to CPSA restrictions, there was often frustration at the length of time it took for revised pass plans to be approved by Scottish ministers. We were told that delays of weeks and sometimes months meant that rehabilitation plans could be stalled, at

times making individual recovery pathways unnecessarily lengthy. This was particularly difficult for those awaiting approval for them to progress from escorted to unescorted passes. We also heard that some suspension of detention plans were unrealistic to deliver in relation to the level of staff escort that was required.

We are aware these issues have been a longstanding concern from across forensic services. This is something that the Commission will continue to raise with the restricted patient team at the Scottish Government.

Summary of recommendations

Recommendation 1:
We repeat our previous recommendations that managers should ensure that nursing care plans are regularly audited to ensure these are person-centred, that reviews fully reflect individual's progress towards stated care goals and that recording is consistent across all care plans.

Recommendation 2:
Managers should continue to work with the estates department to prioritise the improvement of outdoor areas in the Orchard Clinic, so that these offer safe, accessible and welcoming garden and recreational spaces for people to use and enjoy.

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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