Mental Welfare Commission for Scotland

Report on announced visit to:
Royal Edinburgh Hospital, Robert Fergusson Unit, Morningside Place, Edinburgh, EH10 5HF

Date of visit: 18 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

The Robert Fergusson Unit is a national NHS neurorehabilitation service for those with acquired brain injury and associated behavioural disturbance. The unit is staffed by a multidisciplinary team (MDT) with specialist skills in neuro-behavioural rehabilitation.

The unit was designed with capacity for 20 people. Beds have continued to be capped for reasons of safety and to ensure adequate provision of staffing to meet the needs of individuals. On this visit, we were advised that bed numbers were capped at 16.

We had last visited the service in October 2023. The visit was unannounced at that time, not due to any concerns about the service, but as part of the Commission's regular programme of both announced and unannounced visits. Following this visit we made six recommendations to managers. These included the continued transition of clinical records to the electronic record management system, to prevent clinical information about individuals being spread between multiple sources. We recommended regular audits of nursing care plans as well as increasing staff knowledge about the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) and its operation, to ensure that all records in relation to this Act were clearly documented in individual records. We also recommended that managers considered how the access to activities on the unit could be optimised while staffing challenges continued.

In response we received a detailed action plan from the service, outlining goals with timescales for continued improvement work.

On the day of this visit, which was carried out on an announced basis, we wanted to hear about the current experiences of individuals and their carers; to follow up on the previous recommendations and to seek an update on the programme of improvement work.

Who we met with

We reviewed the care records of eight people, six of whom we were able to meet with in person. We spoke with the relatives of five of these individuals.

We talked with the senior charge nurse, consultant psychiatrists and members of the nursing team prior to and during the visit. We also spoke with the chief nurse and clinical service manager when giving feedback to the clinical team at the end of the visit.

We had contact with Partners in Advocacy in relation to individual cases.

Commission visitors

Dr Juliet Brock, medical officer

Anne Buchanan, nursing officer

What people told us and what we found

At the time of our visit, there were 16 individuals receiving care and treatment on the unit. Three individuals were receiving continuous levels of nursing intervention. This had also been the case when we last visited, though the reasons for enhanced support were different in each case (risk factors including risk of falls, risk of self-harm and risk to others).

Although only a few people were able to tell us about their individual experiences, those we did speak with were positive about staff and the care they were receiving. Many of the relatives we spoke with also gave positive feedback about care on the unit and families spoke of feeling welcome when they visited. We also heard comments that the staff asked how family members themselves were coping, which they said felt caring and supportive.

The staff team were described as “excellent” across disciplines, with professionals from nursing, medicine, occupational therapy (OT), speech and language, art and music therapy all being mentioned by carers who spoke with us. Most relatives told us there was good communication about their loved one’s care and treatment.

An issue that was raised was around discharge planning. One relative we spoke with had anxieties about what their loved one’s future care might look like, particularly if they were to return home with support. A few relatives also shared worries about whether their family member would receive the same standard of care when they moved on from the unit. In our discussions with the clinical team, it was evident that professionals were mindful of this. The discharge planning process was designed to involve individuals, their families and future care providers, to make the transition from hospital as smooth as possible. The role of the charge nurse who provided liaison and specialist support between community services and the inpatient team remained highly valued.

Care, treatment, support, and participation

At the time of this visit, eight individuals had been designated delayed discharges. This number remained unchanged from our last visit and was an ongoing concern for the team. The unit remains the only specialist inpatient resource of its kind in Scotland. With half of those receiving treatment on the ward no longer requiring this high level of specialist care, this remained a significant concern for the service. Three people were on the waiting list for admission at the time of this visit.

We were told that monthly discharge hub meetings continued to take place, with all cases reviewed at this forum. Individual cases were also reviewed at the weekly MDT meeting.

The main difficulty preventing people from moving on from the inpatient service remained a lack of appropriate nursing home placements and specialist community resources to meet the complex needs of the individuals awaiting discharge.

Despite liaison from the social worker in the MDT, there were, at times, delays accessing community services via local social work teams, and occasionally delayed legal processes for those requiring welfare guardianship. We discussed with senior managers that earlier referral to local social work services (at the point of admission) could help improve discharge pathways. There was wide agreement of the benefits of this approach, which could help with earlier identification of discharge options and appropriate community resources, as well as ensuring timely application for guardianship powers, when this is required.

We would suggest that the service request an early allocation of a social worker from the relevant local authority for each individual admitted to the unit.

Care records
We saw significant improvements in the care records since our previous visit, with most care records having been transferred to TRAKCare, the electronic individual record management system used by NHS Lothian; there were minimal documents held in paper files.

The daily nursing entries on TRAKCare appeared brief, but included essential information and we noted the use of canned text headings, which appeared to be of benefit. We saw detailed notes from other members of the MDT, including notes of therapeutic work undertaken with individuals. We also found evidence of individual formulations in the notes.

The recording of weekly MDT meetings were of a good quality, with evidence of input from all members of the MDT in discussions. All individuals on the ward were discussed in the meeting, with two people selected for more in-depth review by the team each week. Records provided good evidence of input from families at these meetings and relatives told us that involvement in the meetings was appreciated.

Senior staff told us that a significant piece of work had been carried out since our last visit, with care plans being transferred onto TRAKCare and we were pleased to see clear improvements in this area. The care plans we viewed were detailed and evidenced involvement from individuals and their relatives in the care planning process. There was regular evaluation, as well as evidence of appropriate care plan reviews in real-time (e.g. in response to changes in an individual’s support needs).

We were advised that senior nursing staff were carrying out monthly audits (using LACAS[1] tools) of the care plans for five people randomly selected each time.

Multidisciplinary team (MDT)
The MDT continued to include psychiatry, nursing, OT, art psychotherapy, speech and language therapy (SLT) and social work. Physiotherapy input to the service was also well resourced, with regular visits.

We were pleased to learn that staffing was generally much improved from our previous visit, with the nursing team at 75% of full complement, following successful recruitment. We were told by senior nursing staff that there was no longer a need to use agency staff and that the was only an occasional need for bank staff support. Senior managers were also looking at ongoing workforce needs and provision.

The medical team comprised of two consultant neuropsychiatrists. Following a recent retiral, the additional associate specialist post was being advertised at the time of our visit.

There remained no clinical psychology input in the team and no plans to introduce this, as it was not considered to be a need for the service. Both consultant neuropsychiatrists continued to carry out psychological assessments and formulations, undertook therapeutic work (such as cognitive-behavioural therapy) and devised behavioural management plans with the MDT.

Use of mental health and incapacity legislation

On the day of the visit, 13 of the 16 people on the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Documentation relating to the Mental Health Act and the AWI Act were available in the care files we reviewed.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We discussed whether one individual who was receiving voluntary care was able to give informed consent for their treatment. We heard that the consultant psychiatrist planned to review the individual to consider whether a Mental Health Act assessment was required.

[1] LACAS : Lothian Accreditation and Care Assurance Standards

On this visit, we found improvements in relation to documentation relating to the AWI Act. Where individuals were subject to a welfare guardianship order, copies of legal documents were present in the clinical record.

When 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. In the records we reviewed, we found that section 47 certificates were in place, up to date and accompanied by appropriate treatment plans.

We were pleased to note that there appeared to be more awareness of the AWI Act among the staff team, and we were advised that Band 5 nurses had completed the recommended TURAS training modules since our last visit.

The Commission has continued to work jointly with NHS Education for Scotland (NES) to develop training in relation to the AWI Act. Since our last visit, further eLearning resources have been added and the relevant module can be accessed by anyone in the workforce: Adults With Incapacity (AWI) | Turas | Learn.

Rights and restrictions

Independent advocacy support was provided to the service by Partners in Advocacy. We liaised with this service around the time of the visit and noted, in particular, the enhanced support they were providing to one individual to support them in voicing their views about a proposed transfer to another hospital.

English was not the first language of several individuals receiving care at the time of our visit. The team continued to have good access to interpreting services to support communication, and we were assured that this support was utilised whenever needed.

Activity and occupation

On our previous visit, we heard mixed feedback from individuals and carers about activity provision, as well as concern from the team that staffing shortages had had an impact on the ability to deliver optimal activity and rehabilitation on the unit.

We generally heard more positive feedback in relation to activities on this visit, particularly in relation to groups and activities taking place on the unit, such as discussion groups and film nights. The staff team had support from a part-time OT and a full-time OT assistant. There was input from a music therapist twice a week and we heard that a request for continued funding had been made to managers to continue this beyond six months. An art therapy student visited two days a week and

there were plans for an art therapist to take up post and continue these therapeutic sessions in the future.

Given there were previous concerns about limited activities available on the unit, particularly for those less able to engage with opportunities on the hospital site (such as the HIVE, hospital library or gardens project) or in the wider community, the more positive feedback about one-to-one and group activities on the unit was welcome.

Funding had previously been granted for an activity co-ordinator, but unfortunately recruitment had been unsuccessful. At the time of our visit a vacancy remained for this role. Ongoing funding for the post was strongly advocated by the team, and it was hoped that re-advertising the post at a higher grade (Band 3) would be successful.

The physical environment

The unit is housed in a new, modern building and the internal environment remained light, bright, welcoming, clean and well maintained.

The main communal area on the ward had an open plan sitting and dining space. This provided an area for people to watch television, with an adjacent space for mealtimes and group activities. There was lots of information on the walls, including an orientation board and photographs of all the staff on the unit, in addition to a timetable with information on all activities.

The main communal space also gave access to a large main internal courtyard on the unit. This was open-access and we were told this outdoor space was well used. It provided seating areas, including covered seating, raised beds and a fixed table tennis table. The space appeared to require some maintenance (beds were overgrown and there was some moss on the hard surface). We were told that the estates department had been contacted about this. We were pleased to also hear of plans to continue to enhance outdoor spaces in the unit when funding was in place.

Adjacent to the main communal space was a small therapy room. This had art materials and was used by the art therapist for small groups. We were told the team were looking to acquire more games and equipment for activities, though funding was proving a barrier.

The ADL (activities of daily living) kitchen was well-equipped and had a small table and chairs to seat four people. We heard that this space was well used by the OT team to support one-to-one and small group cooking sessions, including popular breakfast groups.

The unit housed 18 en-suite bedrooms, not all of which were in use. The bedrooms we viewed were in good decorative order and could be personalised if individuals

chose to do so. One four-bed corridor remained designated for females, of whom there were three at the time of our visit. We were pleased to see improvements in the small female sitting room in this corridor, which on our last visit had been cluttered with an excess of furniture and wheelchairs and was used very little. In contrast, on this visit the space had comfortable furnishings, artwork on the walls and had a TV.

The small outdoor courtyard accessed directly from this space had also had improvements, with the addition of a gazebo and seating areas. We were told about plans for introducing raised beds with spring bulbs and a walking rail to aid those who needed support.

Off the ward itself, but near the entrance of the building, there was a family room with facilities to make a hot drink. This continued to provide a comfortable, private space for families to meet with their relative.

Summary of recommendations

The Commission made no recommendations from this visit.

Service response to recommendations

Although we do not require a response to recommendations, the Commission would like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved and will follow this up with the service.

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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