Mental Welfare Commission for Scotland

Report on announced visit to: Royal Edinburgh Hospital, Jordan and Pentland Wards, Morningside Drive, Edinburgh EH10 5HF

Date of visit: 8 March 2016

Where we visited

Pentland ward is a 12-bedded ward for men over the age of sixty-five with a diagnosis of dementia and who display stressed and distressed behaviour. On the day of the visit there were ten patients on the ward. This is a continuing care ward. The ward is situated on the ground floor of the Jardine Clinic within the grounds of the Royal Edinburgh Hospital (REH). It has direct access to a safe enclosed garden. The patient group moved to Pentland ward from Myreside ward in August/September 2015. It is planned to continue this service in a ward in the new Royal Edinburgh Hospital in due course.

Jordan ward is a 14-bedded ward for men over 65 with a diagnosis of dementia and who have complex physical health care needs. It is not planned to continue this service in the new Royal Edinburgh Hospital in the future. It is anticipated that a number of these men will be placed in nursing home care within the next two years. Jordan is situated on the first floor of the Jardine Clinic. Patients have no direct access to the garden but are able to use the garden outside Pentland ward which is directly below. There is one single room on the ward; otherwise men are in dormitory style accommodation which caters for up to four patients.

We last visited both wards in September 2013. At that time Pentland ward patients were placed in Myreside ward which was unsuitable for this group of patients and it has now closed. We will be following up a number of recommendations from this visit.

Who we met with

We met with nine patients between the two wards and reviewed their files. We also met with two relatives on Jordan ward. We spoke with the clinical nurse manager, two charge nurses, staff nurses and the OT assistant on Pentland ward.

Commission visitors

Moira Healy, Social Work Officer and visit co-ordinator

Dr Mike Warwick, Medical Officer

Susan Tait, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

Care plans

We found care plans in Pentland ward to be person-centred. Most care plans we saw had been rewritten recently i.e. within the last month so we cannot comment on the review process. We were pleased to see some care plans related specifically to

management of stressed and distressed behaviour. Care plans contained good individualised information about identified needs. However, we were disappointed that the management plan often included more general content, such as 'use distraction techniques', without identifying specifically what works to calm and redirect that individual. A focus on what works well for each individual helps nursing staff, particularly bank staff, to support the patients with their care when they become distressed.

Patients in Pentland ward had a single sheet of paper on their wardrobe doors with key things staff need to know about them and how to support them e.g. with personal care, person centred approaches for redirection when they are distressed. This is good practice. There was no psychology input to either ward. In particular, this meant that staff in Pentland ward could not undertake NHS Education for Scotland (NES) Stress and Distress in Dementia training. The service has added content on stress and distress to their violence and aggression training. It was disappointing that staff have been unable to undertake the NES training, as this would further enhance their skills in this crucial facet of the care given to this group of patients.

On Pentland ward, nursing files, which included a chronological account of care, and care plans, were easy to navigate, containing relevant and up to date information. Weekly multidisciplinary team (MDT) meeting notes were brief, did not refer to care plans and rarely gave information about attendance. We were disappointed that the clear and detailed documentation in relation to six monthly reviews, which included family members, now seems to have stopped and suggest this is re-instated. These six-monthly reviews included a physical examination and documentation of current physical state and medication by the ward doctor.

Recommendation 1:

Managers should ensure that staff undertake stress and distress training for people with dementia and receive ongoing support from psychology to maintain this.

On Jordan ward nursing files were hard to navigate. This was in part, related to the volume of historical information within files which made finding up to date relevant information quite difficult. Care plans in relation to patients psychiatric care needs were not evident. Physical health care plans were more detailed. However, for a number of people on the ward who had current epilepsy seizures, these were only recorded within chronological nursing notes, with no overview of seizure pattern. There was also no protocol for individual's specific needs or reviews with regard to these seizures.

On both wards life history information was not always well recorded and this should form the basis of any care planning. Care plans in Pentland ward referred to staff completing the 'Getting to know me' proforma and utilising the content of this. The amount of information recorded in this was variable. Managers should consider conducting an audit of life history information and develop their own

recommendations as a result of this. We think that more detailed life histories rather than 'Getting to know me', would be beneficial.

Two relatives we met with on Jordan ward spoke of their anxiety about the proposed discharge of their relative from that ward. Both patients had been resident on the ward a number of years and this is clearly an uncertain time for the family. We were not able to locate any care plans in relation to these proposed plans.

Recommendation 2:

On Jordan ward, managers should ensure nursing care files contain up to date important information in relation to that person's care at that time. Historical information should be archived.

Recommendation 3:

Care plans in relation to patients psychiatric needs should be person centred, individualised and reviewed meaningfully on a regular basis. MDT reviews should include an attendance list, and be reviewed to inform the care planning process.

Recommendation 4:

Patients with current epileptic activity should have care plans/protocols relevant to their needs and a review of epileptic activity should take place on a regular basis.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms

In Pentland we saw some DNACPR forms recently completed on old NHS Lothian paperwork. These have been superseded with the proformas contained in NHS Scotland's guidance (link below). The NHS Scotland form should be used.

http://www.gov.scot/Publications/2010/05/24095633/0

The judgement in the English *Winspear* case [Winspear v City Hospitals Sunderland NHS Foundation Trust (2015) EWHC 3250 (QB)] suggests that, under Article 8 of the European Convention on Human Rights, relatives should normally be consulted in advance of a DNA CPR notice being complete for a patient who cannot consent, and they should certainly be consulted as soon as reasonably practical after it has been completed.

On one DNACPR form in Pentland the doctor had recorded that they had discussed the decision with the welfare proxy, but had not included their name. On another, dated five weeks previously, the doctor had written that this was to be discussed with the next of kin at the earliest opportunity. Discussions with relevant others about DNACPR decisions should be clearly recorded on the form.

Covert medication, input from the pharmacist

Two patients we met in Pentland ward required to receive some medication covertly. Medical staff had completed covert medication pathways, and documented having sought advice from the pharmacist. This is good practice. These and other patients had had pharmacy reviews.

Use of mental health and incapacity legislation

Adults with Incapacity Act (AWIA) Part 5 Consent to Treatment s47 certificates

Where an individual lacks capacity into decisions about medical treatment, compliance with Part 5 of the AWIA is expected. This requires a s47 certificate/treatment plan to be completed authorising treatment.

In looking through the files we found most patients had s47 certificates in place however these were superseded by more up to date certificates which were present in medication charts. The old s47s should be archived with new s47 certificates and treatment plans remaining in the medication charts. Unfortunately, not all certificates authorised the treatment that was prescribed. We saw an s47 treatment plan proforma in routine use in Pentland that we think should be revised. The content should be amended to avoid including treatment for dementia for detained patients, and to ensure that the doctor lists individual medical conditions that are not fundamental healthcare procedures (as listed in the code of practice for Part 5). We were pleased to see that documentation in relation to Welfare Guardianship or Powers of Attorney were held within the notes. Unfortunately, this documentation was not filed consistently and was therefore not always easy to find. A record of how the proxy decision maker would like to delegate these powers was not present.

Recommendation 5:

Managers should ensure that all individuals who do not have the capacity to consent to their medical treatment have an individualised s47 certificate/treatment plan in accordance with the Code of Practice in relation to Part 5 of AWIA.

Recommendation 6:

We would recommend that powers or attorney and welfare guardians are identified on the front page and were held in a consistent place within the file so that they would be easy to find. We also recommend using the Mental Welfare Commission checklist for people who have a welfare guardian or power of attorney which then acts as a record of how the guardian or attorney wishes to delegate those powers (if at all) .

Activity Provision

On Pentland ward there was an OT assistant two days per week and an occupational therapist (now on maternity leave) two days a week. We were told that

a new post for an activity co-ordinator had just been advertised. There was a specific activity room within Pentland ward which was well equipped with games, musical instructions, arts and crafts and rummage boxes. The OT assistant told us she gets to know her patients well in order to find activities that the individual patient will enjoy and participate in. Most of her activities are conducted on a one to one, person centred basis however some are done on a group basis. Recording of these activities are held within the daily notes. In addition to this input, it was evident that throughout the day nursing assistants were involved on a one to one basis with patients to assist with activities and communication.

In Jordan ward there was very poor provision of activities. The patients on this ward have very high physical health nursing needs and this dominated the nursing input that was available. However, it is important to also provide a meaningful day for patients who are unable to initiate this for themselves.

Recommendation 7:

Engagement in therapeutic activities is a core element of care. Managers should undertake an audit of activity provision on Jordan ward and make recommendations with regard to improved access to activities for patients on this ward to ensure that each individual has a meaningful day.

The physical environment

Both wards were clean and bright.

On Pentland ward, most of the men have single rooms with en-suite facilities. There is one twin room which was occupied by one man on the day of the visit. The bedrooms are spacious. Some rooms were decorated to a personal taste and some rooms seemed to be fairly clinical, considering the length of time some of the patients had lived there. The corridors are wide and there are numerous places to sit throughout the ward both in the communal areas and in quieter spaces. We were told that the incidents of aggressive behaviour have significantly reduced since the move from Myreside, which is thought to be related to the spacious feel of the ward. Pentland ward has the advantage of being on the ground floor with direct access to a spacious, safe and interesting garden area. We were told that recent allocation of funds of £8,500 means plans are in place to create pathways and rest spaces with benches in the garden. This garden is also available to patients in Jordan ward but they have to take a more circuitous route to get there.

In Jordan ward there is one single bed room, the remainder of the bedrooms were larger 4 bedded areas. Most of the bedrooms and bed spaces lacked personalisation despite some of the men having lived there for several years. There are two main communal sitting areas. On the day of the visit most patients were using the larger dining-room/lounge which was stark and clinical. It was also very

noisy due to the echo effect in a large room. The smaller lounge, which was not used on the day of the visit, was more domestic in size and was more comfortable.

On Pentland ward we noted that duvet covers were not present on most beds. We were told that laundry services are no longer on site and this had a direct impact on the amount of laundry that was delivered to the ward. This is a poor reflection on the physical environment and is also unhygienic. This should be raised with facilities management as soon as possible. This does not reflect well in relation to the dignity of these patients.

Recommendation 8:

In Jordan ward managers should endeavour to secure funding for artwork and work with Estates to consider the use of soft furnishings and a room divider to absorb noise and reduce the stark clinical feel of the ward environment.

Recommendation 9:

Managers should review the personalisation of patient bed areas and give consideration to further support individuals to have more personalised bed space**.** Appropriate bedding should be available for the patients in Pentland ward.

Any other comments

We saw evidence of warm and dignified interactions between staff and patients. The staff we spoke to had an in-depth knowledge of individual patients.

Two relatives we met within Jordan ward were highly complementary regarding the care their family members had received whilst on the ward.

Summary of recommendations

Recommendation 1:

Managers should ensure that staff undertake stress and distress training for people with dementia and receive ongoing support from psychology to maintain this.

Recommendation 2:

On Jordan ward, managers should ensure nursing care files contain up to date important information in relation to that person's care at that time. Historical information should be archived.

Recommendation 3:

Care plans in relation to patients psychiatric needs should be person centred, individualised and reviewed meaningfully on a regular basis. MDT reviews, which should include an attendance list, should be reviewed and contain information which informs the care planning process.

Recommendation 4:

Patients with current epileptic activity should have care plans and a review of epileptic activity should take place on a regular basis

Recommendation 5:

Managers should ensure that all individuals who do not have the capacity to consent to their medication have a s47 certificate/treatment plan. In accordance with the Code of Practice in relation to Part 5 of AWIA

Recommendation 6:

We would recommend that powers or attorney and welfare guardians were identified on the front page and were held in a consistent place within the file so that they would be easy to find. We also recommend using the Mental Welfare Commission checklist for people who have a welfare guardian or power of attorney which then acts as a record of how the guardian or attorney wishes to delegate those powers (if at all).

Recommendation 7:

Managers should assess the level of activity provision on Jordan ward and make recommendations with regard to improved access to activities for patients on this ward.

Recommendation 8:

In Jordan ward managers should endeavour to secure funding for artwork and work with Estates to consider the use of soft furnishings and a room divider to absorb noise and reduce the stark clinical feel of the ward environment.

Recommendation 9:

Managers should review the personalisation of patient bed areas and give consideration to further support individuals to have more personalised bed space**.** Appropriate bedding should be available for the patients in Pentland ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland

Mike Diamond

Executive Director (Social Work)

12 April 2016

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 MWC 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 individual care, treatment and support is 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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