Mental Welfare Commission for Scotland

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

Date of visit: 27 March 2018

Where we visited

Canaan, formerly Ward 14, and Fairmile, formally Canaan Ward, are dementia assessment wards for people over the age of 65 years in Edinburgh. Canaan is a male ward and Fairmile is for female patients.

In June 2017, both wards moved to purpose-built facilities in the newly opened Royal Edinburgh building, on the Royal Edinburgh Hospital site.

The new wards each have 15 beds, providing single en-suite facilities for every patient. Bed numbers in each ward had been reduced gradually from 20 to 15 in recent years in preparation for this move.

We last visited this service on 29 March 2016 and made recommendations about nursing staff levels, care planning, consent to treatment, welfare proxies and the physical environment.

On the day of this visit, we wanted to follow up on the previous recommendations and to observe how the new ward environments were working for staff and patients.

Who we met with

We met with and/or reviewed the care and treatment of 11 patients and met with five carers/relatives/friends.

We spoke with senior charge nurses on both wards, to nursing staff, an activity co-ordinator and the consultant psychiatrist on Fairmile ward.

Commission visitors

Juliet Brock, Medical Officer

Susan Tait, Nursing Officer

Claire Lamza, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

When we visited, all beds were occupied on the male ward. The female ward had two empty beds. Previously it was not unusual for the female ward to have a waiting list of five to six patients.

On the morning of our visit, the atmosphere on both wards was calm. Patients were already up, dressed and engaging in activities.

Throughout the visit the interactions we witnessed between staff and patients were warm, caring and respectful. The staff we spoke with had good knowledge of individuals under their care, including of their home and family circumstances.

Among the patients whom we met, some were more able to discuss their care than others. A number of patients on each ward spoke positively about staff and the care they were receiving. Individuals said they enjoyed speaking to the staff and were 'happy' in the unit, with one man describing the standard of care as 'perfect'. There were no negative comments from patients.

We met with carers in Canaan and Fairmile. On both wards carers told us their relative was well looked after, that the nursing staff were caring and that they felt welcome on the ward. One carer described the care in Canaan Ward as 'exceptional', remarking that the kindness shown by the team extended from the consultant psychiatrist through to the domestic staff. Most carers told us they felt well informed and involved in discussions and decisions about their relative's care and treatment.

We were pleased to see 'Getting to Know Me' documentation completed for each patient and clearly visible, at the front of medical notes in Fairmile or within care plan documents in Canaan.

On Fairmile Ward, the psychiatrist has supported medical students in developing and piloting an 'All About Me' sheet for each patient. This is completed with patients and their relatives. It incorporates photos and brief captions about the person and their interests. Patients are given the option of having a copy displayed on their bedroom door, or inside their room if they wish for more privacy. The visibility of the 'All About Me' information helps patients recognise their own room and also enhances the person-centred feel of the ward. We were pleased to hear plans for the staff group to continue this initiative beyond the pilot.

Care planning documentation and processes have been reviewed and significantly improved since our last visit. Ongoing audits are also taking place. The senior charge nurse on Canaan ward has established training workshops and supervision across both wards, which has improved the standard of nursing staff care plans.

In general, we found the care plan documentation was detailed, person centred and of a high standard. There were particularly good examples of stressed and distressed behaviour management plans, informed by details gathered from relatives and 'Getting to Know Me' documentation. On Fairmile Ward, we found the quality of some care plans to be variable. However, reviews were thoughtful and clearly documented. There was good evidence of participation in care planning with patients, where able, and with their carers. Both charge nurses continue to work with staff on consistency and quality in this area and we look forward to seeing ongoing work on future visits.

We found general clinical documentation to be of a good standard. Weekly multidisciplinary team meeting (MDT) notes are completed on the SCAMPER format, developed by a clinician at the Royal Edinburgh Hospital and now widely used. This documentation, entitled 'Structured Review of Patient Care', with key categories forming the acronym SCAMPER, enables comprehensive recording of team discussions, encouraging reviews of all aspects of clinical care and treatment planning

at each MDT. We found this documentation well used and completed in the patient files we reviewed.

There was evidence of referral and involvement with other professionals such as occupational therapy (OT) and social work.

On both wards we also found documentation of patient engagement in activities and one-to-one nursing time. Where staff supported patients in activities outwith the ward, this was recorded, as was contact with family and friends.

On our last visit, we saw Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms which were either not properly authorised or had been completed without consultation with family. On this visit DNACPR documentation we viewed was appropriately authorised and completed in consultation with family and/or welfare proxies where appropriate.

On our previous visit, staffing levels on the male ward had been highlighted by several carers as an area of concern. At that time, high levels of one-to-one nursing observations were an issue. We recommended that senior nurse managers undertake a review of staffing levels and consider what additional action was required.

No concerns were raised on this visit about staffing levels on either ward. Indeed, Fairmile staff advised us that no patients had required constant observations for several months and that enhanced observation levels had markedly reduced since the move to the new site. Nursing staff attributed this to a number of possible factors: a positive improvement in the ward environment for patients, good staffing levels, and recent training, with 11 of the team having undertaken stressed and distressed behaviour management training. The plan is for all staff to now receive this training. We were pleased to learn that the senior charge nurse on Canaan Ward is now a trainer in stress and distress management. The Newcastle model of care is promoted across the unit.

Both wards have access to expertise from psychology, OT, speech and language therapy, dietetics and physiotherapy. This can be arranged by individual referral.

Use of mental health and incapacity legislation

At the time of our visit, four patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA) across both wards. Many patients had either power of attorney or guardianship in place under the Adults with Incapacity (Scotland) Act 2000 (AWI).

In general we found good documentation and record keeping across both wards in relation to the MHA and AWI. Details of welfare proxies were clearly recorded, with copies of documentation relating to guardianship order/power of attorney easily located in patient files.

When patients required s47 consent to treatment certificates under AWI, these were completed, up to date and copies were easily accessed. S47 documentation had improved since recommendations were made on our previous visit, however not all s47 certificates on Fairmile Ward had accompanying treatment plans. Treatment plans should usually be completed with an s47 certificate, in accordance with Part 5 of the AWI Act.

http://www.gov.scot/Publications/2010/10/20153801/0

We reviewed medication prescription sheets on both wards and found appropriate authorisation (T2/T3 certificates) for patients receiving treatment under the MHA.

Rights and restrictions

Both wards have a locked door policy. Although easy-read information about this policy was displayed outside Fairmile Ward for visitors, we suggested it was also displayed inside for patients.

Most patients had escorted time off the wards. Pass plans and appropriate risk assessments were in place for this. Any restrictions, such as bed rails, had accompanying care plans, which were reviewed weekly.

We reviewed the care of one informal patient on Fairmile Ward and asked the consultant to review their status on the ward with a view to considering if detention under the MHA was indicated.

Activity and occupation

Both wards have impressive activity programmes, run by full time activity co-ordinators and nursing staff. Each ward has a weekly activity timetable that is clearly displayed.

A diverse range of individual and group activities is provided, both on and off the wards. Examples include craft sessions, music therapy, relaxation, walking, gardening and art link. We were told that regular protected engagement time is valued by both patients and staff, encouraging everyone to participate in the activities on offer.

Volunteer organisations also contribute to the programme, with activities including Playlist for Life, Storytelling in Dementia, and Elderflowers Music in Hospitals. The OT is looking to introduce ‘therapony’ visits.

Weekly outings are arranged for patients on both wards and include trips to the cinema or places of interest, such as the Royal Yacht or botanical gardens. A regular fixture for both men and women is dancing at a local miners club. Partners are encouraged to join these outings.

Individual activities are also encouraged according to each person’s interests. On Canaan Ward, planned activities for men and their wives are encouraged. Couples

have chosen to have ‘date nights’ with cinema visits or going for a meal or doing other things they enjoy such as walking the dog.

Fairmile Ward has recently started producing a newsletter about activities that are planned in the month ahead, with copies provided in each patient’s room.

The physical environment

The environment of both new wards is bright, spacious and welcoming. The design and decoration is dementia friendly, with clear signage and handrails throughout. The spacious day area on each ward looks out onto an enclosed courtyard garden.

Staff told us that morale has increased since the move. They have also noticed improvements in patient wellbeing, such as reduced levels of distress and better sleep, since the introduction of individual bedrooms.

The addition of in-built technology enhances patient safety, such as laser alarms installed above each bed, which can be used to help reduce falls risk.

Each bedroom has en-suite shower facilities and the wards also have large accessible assisted bathrooms, for those preferring to have a bath.

The teams on both wards are gradually introducing artwork and objects into the environment to provide interest for patients. These include display cabinets which change with the seasons in Fairmile, and a suitcase full of memorabilia on Canaan Ward.

The garden space on each ward offers seating, shaded areas and raised beds. Volunteers from the Cyrenians gardening project are training nursing staff to support patients and relatives to tend the garden if they enjoy this. The activity co-ordinator on Fairmile Ward has applied for funding to make the courtyard more dementia friendly, enabling everyone to access this space. Physiotherapy input has also been sought to introduce an outdoor exercise area suitable for the patient group.

One of the unique aspects of the new unit is the dementia café on Canaan Ward. This is a thoughtfully designed room that has period furniture, fixtures and fittings. There are a number of tables where patients from either ward can sit and enjoy refreshments with their spouse, family or friends. Volunteers support use of the café and a visitor’s book is full of comments showing how much the café is used and enjoyed.

There was a lack of lockable wardrobe doors on the fitted storage unit in each bedroom. This was highlighted to us as a particular issue on Canaan Ward where, because of the behaviours of some individual patients (removing or damaging items from other men’s rooms), the clothing of every patient was having to be stored in a separate room. This was a less restrictive alternative to locking patients’ bedrooms and preventing access during the day. The current arrangement, however,

disadvantages some individuals as they cannot select clothing from their own wardrobe.

Recommendation 1:

Managers should address the lack of lockable storage in patients' bedrooms.

Any other comments

Staff spoke positively about the benefits of the rapid response team. This fairly new team aim to support people in the community for longer and work closely with both wards to help reduce unnecessary admissions. We were told that their input has eradicated the need for waiting lists for Canaan and Fairmile.

The team is based in the same building as the wards and is well staffed by nurses, with consultant input. The wards describe good liaison with this service and say this joint approach improves patient journeys - both to admission and discharge. The rapid response team can support early discharge if mental health care at home is needed.

We were advised of delayed discharges for some patients however. This is in cases where social work input is required for residential care or nursing home applications. Delays in social work assessment and allocation are being addressed at the hospital's weekly delayed discharge meeting, attended by social work managers.

Summary of recommendations

1. Managers should address the lack of lockable storage in patients' bedrooms.

Good practice

We found several areas of good practice, which have been detailed in this report.

These include:

- Staff training programme in stressed and distressed behaviour management
- Excellent, imaginative and varied activity programmes on both wards
- Pilot project introducing visible 'All About Me' information on Fairmile Ward
- Dementia café on Canaan Ward

Service response to recommendations

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

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

Alison Thomson
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 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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