Mental Welfare Commission for Scotland

Report on announced visit to: Comiston Ward, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh, EH10 5HF

Date of visit: 3 October 2018

Where we visited

Comiston Ward is a 13-bedded mental health rehabilitation ward for men and women over 65 years of age. Most patients admitted to Comiston are transferred from the assessment wards for older people at the Royal Edinburgh Hospital. In Comiston, rehabilitation support is provided to enable people to return home or move on to other suitable accommodation.

We last visited this service on 8 November 2016 and made recommendations regarding clinical psychology provision, care planning and recording activities, improving documentation relating to the Adults with Incapacity (Scotland) 2000 Act (AWI Act), and some environmental issues.

On the day of this visit we wanted to follow up on previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of six patients and met with two relatives. We spoke with the senior charge nurse and other nursing staff on the ward.

Commission visitors

Juliet Brock, Medical Officer

Susan Tait, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

On the day of our visit there were 10 inpatients on the ward and three empty male beds.

During the visit we observed warm interactions between staff and patients. The nursing team were encouraging and supportive towards patients in their care, and the atmosphere on the ward was calm and relaxed. Some patients were participating in a ward-based group activity in the morning, while others had time off the ward to engage in activities in the hospital or community, in accordance with their individual rehabilitation programme.

The patients and relatives we met with described the care provided on Comiston Ward as excellent. Relatives we spoke with also said the communication from the clinical team was good, and they felt involved in decision making about the ongoing care of

their family member. They told us that staff were very approachable and they were made to feel welcome when visiting the ward.

The multidisciplinary team (MDT) includes the consultant, junior doctor, nursing team and the occupational therapist (OT) and OT assistant. The OTs have dedicated input to the ward, offering individualised assessments and home visits. Referrals can be made for input from other disciplines including dietetics, speech and language therapy, and physiotherapy when required. We were told that physiotherapists check in with the staff team regularly to see if their input is needed.

At the time of our last visit, we were disappointed to hear that the clinical psychologist no longer attended the ward round and there was no longer dedicated clinical psychology input to the ward. We made a recommendation on our last visit that managers review the provision of psychological therapies on Comiston, including the need for dedicated clinical psychology provision.

On this visit, we were advised by the team that there is still no dedicated clinical psychology provision to the ward. If a patient requires psychological therapy, an individual referral is made. We were told there is a long waiting list for clinical psychology, and patients are often not seen for assessment until they have been discharged and are back in the community.

We were advised that the charge nurse has applied for funding to undertake training in cognitive behavioural therapy. We understand that this will be supported in the long term by supervision provided by clinical psychology.

We repeat our previous recommendation on this issue:

Recommendation 1:

Managers should review the provision of psychological therapies in Comiston. This should include consideration of the need for dedicated clinical psychology provision, both for direct work with individuals and for supervision and support of nursing staff in the delivery of psychological therapies.

At present, patient files are kept in paper format. It is planned that the ward will be moving to paperless notes from the end of October, via the online TRAK system used in NHS Lothian.

The nursing care plans for the patients on the ward were of variable quality. While some were person centred with a good level of detail, many of those we reviewed lacked personalisation and did not offer useful descriptions of the interventions required to support the individual. However, there was evidence of regular, often

thoughtful, care plan reviews, with some evidence of patients participating in this process.

We repeat our previous recommendation in relation to this issue:

Recommendation 2:

Managers should further develop nursing care planning procedures to include more individualised interventions and evaluation of each intervention when the care plan is reviewed.

Since our last visit, the clinical team on Comiston have introduced new team meeting documentation, which was developed elsewhere in the hospital (the documentation is known locally as 'SCAMPER'). The documentation of weekly ward rounds is now much improved using this format. We saw good recording of those in attendance and clear decision making, outlining ongoing plans for patient care. In the notes we also found good evidence of pharmacy reviews in some files and excellent in-depth OT reviews.

Use of mental health and incapacity legislation

When we visited, none of the patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHA).

Section 47 of the AWI Act authorises medical treatment for people who are unable to give or refuse consent. We found s47 certificates appropriately completed, with accompanying individual treatment plans.

We did however find a lack of clarity regarding patients who had welfare proxies under the AWI Act. It was not clear in some of the casefiles we looked at whether or not the patient had a welfare power of attorney. Where they did, it was sometimes unclear which family member held this legal authority and what powers they had. When we asked about individual cases the staff were not always clear about this issue.

It is essential that staff are aware when a patient has a welfare guardian or power of attorney under the AWI Act. When the patient has a welfare proxy, there should be clear recording of who the welfare proxy is, their contact details, and a copy of documentation to confirm the legal powers that the welfare proxy holds. The Commission has a quick reference guide that staff may find useful:
https://www.mwcscot.org.uk/media/241253/poa_leaflet_care_homes.pdf

We repeat our previous recommendation on this issue:

Recommendation 3:

Staff should ensure that, if there is a welfare proxy, they obtain a copy of the guardianship order or power of attorney and file this in the patient's notes.

Rights and restrictions

We found 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms present in the front of patient notes we reviewed. Whilst some of these forms were appropriately completed, we found three forms that had been signed by junior doctors without evidence of consultation with the patient's welfare proxy and/or relatives and without documented authorisation from the consultant in charge of the patient's care.

Where an entry had been completed by the junior doctor in the patient's notes, the documented discussion with the patient (and the reasoning provided for the DNACPR status) appeared to us as insufficient, and we were concerned that in individual cases, the patient may not have had the capacity to make this decision.

These DNACPR forms had been completed by different doctors. They had been signed during each patient's journey through older people's inpatient care at the hospital. Each had been completed prior to the patient being admitted to Comiston ward.

The Scottish Government produced a revised policy on DNACPR in 2016: https://www2.gov.scot/Resource/0050/00504976.pdf

This makes it clear that where an adult cannot consent and has a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give or not to give CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded.

We discussed this issue with senior staff on the day and requested that every patient on the ward who had a DNACPR form had this urgently reviewed by the consultant psychiatrist to ensure that appropriate decisions about CPR had been made, with the necessary discussions, and that documentation was in place to record this.

We also asked the associate divisional medical director to consider any training needs for medical staff in the hospital in relation to DNACPR decision making.

Recommendation 4:

Managers should ensure that when patients are admitted to Comiston Ward, if a DNACPR form is in place, this is reviewed by the clinical team. Audits of all DNACPR forms should be routinely carried out.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

This can be found at https://www.mwcscot.org.uk/rights-in-mind/

Activity and occupation

Social and therapeutic activities are provided by nursing staff on the ward and by the OT and OT assistant, who also support people on an individual basis to access the community and their homes. Patients can also attend activities at the Hive (the activities centre within the hospital run by the Scottish Association for Mental Health) and the gardening project within the hospital grounds.

The ward no longer has a dedicated activity co-ordinator. Staff sit down with each patient every week to help them plan their week ahead. Patients we spoke with told us that they found this very helpful.

As reported on our last visit, we found variability in the documentation of patient participation in activities by ward staff. We repeat the following recommendation:

Recommendation 5:

A record should be kept of the individual's participation in planned activities and this should be regularly reviewed and evaluated.

The physical environment

Comiston Ward is housed in an old building on the hospital site and has been refurbished and updated over the last 10 years.

The female bedrooms are provided in a four-bedded and two-bedded dormitory. Three separate two-bedded rooms are generally occupied by male patients, with a single room available to be used for either a male or female patient, depending on requirements at the time.

We found that some of the toilet and bathroom areas on the ward were rather uninviting and cramped, appearing cold and institutional, with old sanitary fittings. Due to the age and nature of the building there appears a lack of flexibility to update some areas of the ward.

There is a communal area in the middle of the ward, by the nurses' office, which has been pleasantly decorated and furnished to offer patients a space to sit. We felt that the main communal lounge area could, however, be made more inviting and comfortable for patients.

There was good signage throughout the ward, and lots of information leaflets and posters on the walls about activities and groups, in addition to pictures.

There is an enclosed garden area accessed directly from the ward. Patients can access the garden when they wish, and do not need to be supervised. It is a pleasant space with raised beds and seating areas, which is tidy and well kept. The concrete surface underfoot is, however uneven and cracked in places. We felt this could pose a potential risk to those with mobility problems, as it appeared to be a trip hazard.

Recommendation 6:

Managers should review the garden area to consider whether repairs are needed to the concrete surface for patient safety.

Any other comments

We were advised that two patients recently admitted to Comiston needed to wait for female beds to become available on the ward. At the time of our visit, three of the 10 patients on the ward had their discharge delayed.

Although staff described good contact with social work colleagues, they explained there can be long waits for care packages to be put in place to support patients at home, or for placements to be found. One family we spoke with felt that the delay in arranging a home care package had led to their relative losing the remaining skills they had to live independently. The clinical team shared the concern that for some individuals, significant delays had meant that a care home placement had become a more appropriate option than the individual returning home with support.

Staff told us that the OT team are proactive and often arrange care packages themselves where possible. The inpatient team also offer outreach support on a short-term basis if needed to fill any gaps when a patient is discharged whilst waiting for care to start.

We were told that the City of Edinburgh Council are about to change the way they offer some packages of care. The team hoped that this could lead to some improvements in the process and potentially reduce lengthy delayed discharges in the future.

Summary of recommendations

1. Managers review the provision of psychological therapies in Comiston. This should include consideration of the need for dedicated clinical psychology provision, both for direct work with individuals and for supervision and support of nursing staff in the delivery of psychological therapies.

2. Managers should further develop nursing care planning procedures to include more individualised interventions and evaluation of each intervention when the care plan is reviewed.

3. Staff should ensure that, if there is a welfare proxy, they obtain a copy of the guardianship order or power of attorney and this this in the patient's notes.

4. Managers should ensure that when patients are admitted to Comiston Ward, if a DNACPR form is in place, this is reviewed by the clinical team. Audits of all DNACPR forms should be routinely carried out.

5. A record should be kept of the individual's participation in planned activities and this should be regularly reviewed and evaluated.

6. Managers should review the garden area to consider whether repairs are needed to the concrete surface for patient safety.

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.

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. We visit 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 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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