mentalwelfare
commission for scotland

Older and Wiser

Findings from our unannounced visits to NHS continuing care wards

Who we are

We are an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We're made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should

- be treated with dignity and respect;
- have the right to treatment that's allowed by law and fully meets professional standards;
- have the right to live free from abuse, neglect or discrimination;
- get the care and treatment that best suits his or her needs; and
- be enabled to lead as fulfilling a life as possible.

Our visits

The Commission visits people in a range of settings throughout Scotland. As part of our programme we visit people who are receiving care and treatment in hospital settings. Many of those people are older and affected by dementia. For some, their physical and mental needs are such that they require intensive nursing care and support as well as regular medical supervision and intervention. That level of care is mostly provided in NHS continuing care hospital wards.

The care and treatment needs that these units are set up to meet are complex and challenging. Many of the people who are patients in these wards have dementia, but some have other types of mental illnesses and many have physical illnesses associated with old age. For some people, their illnesses can affect their behaviour in way that can pose a risk to themselves or to others. If you or someone close to you had these kinds of needs, it is very likely you would want to be cared for and treated in a pleasant environment by staff who have the skills and resources necessary to provide kindly and sophisticated professional care.

Continuing care for people with dementia does not have a very high profile in the public consciousness. This is surprising given the projected growth of the number of people with dementia over the next 20 years. Alzheimer Scotland project an increase from around 58,000 in 2007 to around 102,000 in 2031. We decided to carry out an unannounced visit to a number of NHS continuing care wards for older people, to meet with patients and staff and build a picture of the kind of care that someone could expect to receive if admitted to hospital in Scotland today. On our visits we were interested, not just in the kind and quality of care available; we also wanted to gain an impression of the general quality of life for the patients who live in these facilities.

No-one would argue with the precept that care and treatment should be based on individual needs. The trouble is that many factors can mitigate against this. Resources, organisation and philosophy of care, attitudes and staff training all have a part to play. We were particularly interested to gain an impression, from the specific areas of care that we looked at, as to whether care for people in continuing care wards is driven more by individual need or more by resource availability.

Why carry out unannounced visits?

We have found through experience that unannounced visits help give a clear and uncluttered view of a care setting as it carries out its day-to-day operation. We were generally welcomed by patients and staff, who were very willing and happy to give their views on the places we visited.

How we carried out the visits

We visited 16 continuing care wards across Scotland. Some of these wards were also used to assess individuals' care needs before they were moved to other care settings. Our visits were unannounced and took place in the early evening. Each ward was visited by 2 or 3 Commission staff who met with patients and any relatives or carers who were present. We took time to look around the wards to gain an impression of the environment. We asked staff a number of questions about the care being given in the wards. We examined 2 sets of notes in each ward, paying particular attention to the assessment of needs and the way those identified needs were being met. By looking at these different sources of information we were able to build a picture of care in the wards that we visited.

Table 1

Wards visited and number of patients

Hospital	Ward	Beds	Male patients	Female patients
Stratheden	Bayview	12	9	0
Vale of Leven	Fruin	14	3	9
Kelso	Poynder View	16	5	9
Ayrshire Central	Pavillion 1	18	8	4
Gartnavel Royal	Tate House	22	4	17
Whyteman's Brae	Seaview	28	6	9
Murray Royal	Kinclaven	12	8	4
New Craigs	Torvean	12	9	3
Tippethill	Rosebery	30	0	28
Huntly	Gordon Villa	12	3	5
REH	Canaan	20	0	20
Bonnybridge	Ward 3	24	13	7
Rosslynlee	CC1	12	0	12
Ravenscraig	Dunrod F	26	10	12
Cleland	Parkside North	15	0	15
Liff	Ward 19	17	14	0
Totals		290	92	154

Information to patients and relatives

Hospital admission for anyone can be confusing and bewildering. For an elderly or infirm person with dementia, moving into a strange new environment can be frightening. It is important that as much as possible can be done to communicate effectively and that information is available for the person being admitted and his or her relatives. When possible, preparing people for admission to hospital is essential and staff must use their skills in communicating and anticipating the anxieties and concerns that someone coming into hospital may experience. It is also important to have written information for patients and relatives that lets them know what to expect, who does what and gives a picture of what services, facilities and activities are available. Whilst staff in most areas were aware of the information that should be available, less than half of the areas had information on display regarding how to get specific information about the ward,

or about particular medical conditions. No information was found to be in any language other than English. We think that services should be clear about the minority ethnic groups that they may have to care for and have appropriate written material available.

What relatives said

Of the relatives we spoke to 11 agreed to give their views about care in the wards visited. We asked them about the level of information they had received. The response was somewhat mixed with 7 stating they had received good information on dementia and 10 saying they were informed of treatment changes. 9 relatives said that they felt welcomed into the ward, with 8 agreeing they were encouraged to participate in the care of the patient.

However, not all were aware of who their relative's doctor was, or the nurse who coordinated their relative's care on the ward.

The relatives we spoke to had some clear ideas about how life could be improved on some of the wards. These are some of their suggestions:

- more staff time to spend with patients
- more stimulation and activities on the ward
- more time away from hospital
- wider and more appropriate television channel choice
- improved food
- places to store patients' favourite food
- en-suite toilet facilities
- more storage space for clothes

This said, there was – praise for staff and the level of care provided

"Staff are more than helpful, it's a great place" (relative – Pavillion 1 Ayrshire Central).

"The staff really care" (relative – Parkside Ward, Clelland Hospital).

We were interested to see that 6 of the wards visited could offer overnight accommodation to relatives of patients who were very ill. We thought this to be sensitive to the needs of relatives and very good practice. We encourage other services to provide the same facilities.

Environment – Quality

"... it should be recognized that the role of the physical environment need not be limited to the simple provision of shelter; the environment represents a potentially important, albeit frequently underused, therapeutic intervention..."[1]

Given that continuous care wards can be 'home' to a patient for some time, we were particularly interested in the quality of the environment in the places we visited. It can be hard to provide a homely environment in a hospital setting, but it can be done. We were looking for thoughtful and innovative ways of helping people with dementia live comfortably in their environment. Things like safe, easily accessible areas with signage that is recognisable to people whose memory and orientation may be affected by dementia. Simple things can help in big ways. Signs to the toilet that can be easily recognised can help avoid problems with incontinence. A picture on a door can help someone with memory problems recognise their bedroom. Having recognisable focal points, like a fireplace, in a day room can help give a domestic scale and friendliness to a hospital ward. Limiting noise can reduce confusing and unnecessary stimulation and make the environment more restful. There is nothing worse than a loud radio playing in one area and a TV in another, both within earshot. Good lighting is also essential, the older we all get the more light we need to read and to see what is going on around us. The risk of falling can increase with age so it is particularly important that wards are, within reason, tidy to reduce the risk of tripping up over something left lying around, like lifting equipment or a parked wheelchair. Environments that are clean and fresh help to promote a general feeling of wellbeing.

We were pleased to see, and hear, that none of the wards visited had noise problems. All but one had quiet areas where patients could find some peace and quiet. Our visitor to Bayview Ward in Stratheden Hospital was heartened by *"the pleasant buzz of conversation and laughter in the sitting room from patients, staff and their visitors"*. However another of our visitors commented on another environment that was *"a safe, protective environment with dedicated staff but totally bland, unstimulating and not dementia friendly"*.

In general, all of the wards visited were reasonably clean, although in 3 wards visitors noted that unpleasant smells were apparent. In all the wards visited redecoration had taken place at some time over the last 5 years. However, only 6 of the areas were noted to be dementia friendly in their decor. We observed that 12 of the wards were well ventilated and had good natural light.

[1] Weisman *et al* 1991 cited by Archibald C. Specialist Dementia Units: A Practice Guide for Staff Dementia Services Development Centre 1997.

The most striking observation was of the wide range of quality of environments across NHS wards.

We were concerned to hear that 5 of the wards visited had significant problems with temperature control. Only 5 of the wards visited had good, clear signage. While this was disappointing, it is something that can be easily, and cheaply, rectified.

One of our visitors commented that Pavillion 1 in Ayrshire Central Hospital was *"bleak, institutional and depressing"* whilst in contrast the visitor to Ward 3 in Bonnybridge Hospital found it to be *"sensitively designed for dementia patients"*. Staff do not want to care for patients in an unpleasant or unsuitable environment and many of those we spoke told us of the improvements they would like to see. There were some wry comments made by staff about the quality and suitability of some wards. One nurse said that she was looking forward to her ward being refurbished and upgraded in 2007. She said *"I'm looking forward to moving into the new century"*. However, she meant the 20th, not the 21st century.

We noted that 9 of the wards had direct access to enclosed garden areas, but only 7 of these gardens were designed to be dementia friendly, having easy to walk on wide pathways with seating dotted along the paths and raised flower beds.

Some improvements require major financial investment, but many can be achieved with limited resources and imaginative thinking.

Perhaps the most striking observation was of the wide range of quality of environments across NHS wards that are fulfilling the same function. Some homely and reassuring, some not. One of our visitors commented *"I left with a real sense of disquiet"*.

Privacy and dignity

In 11 of the wards, bedrooms were noted to be easily accessible, but only 5 of the 16 wards had single rooms and 8 wards were noted to be single sex accommodation. Disappointingly, 3 of the wards that were mixed sex environments had little or nothing in place to cope with the issues encountered.

The wards for this particular age group inevitably have to deal with physical ill-health on a regular basis. It was encouraging to find that 9 of the wards had quiet areas, where people with physical illness could be nursed in peace and with privacy and dignity. In saying that, however, all wards should be able to offer appropriate facilities for very ill people.

Unfortunately only 6 of the 16 wards had facilities for relatives to stay over night.

Assessment of Care Needs

We asked specific questions about assessment of care needs because we wanted to find out if people were receiving the care they needed, as opposed to what was available within that service. Initial assessments were mostly carried out by medical staff with input from other disciplines as required. Nurses and staff from other disciplines carried out further assessments following admission. In the course of asking about the care and treatment of people in the wards visited, we were

struck by the variety of ways that care needs were assessed. These ranged from formal assessment tools such as the revised elderly persons disability scale (REPDS) used in 5 wards, discipline specific general assessment tools used in 10 wards and 9 wards that regularly carried out assessment of activities of daily living. Some very specific assessment tools such as Waterlow risk assessment (pressure sore risk assessment) was used in 6 areas and a general risk assessment tool used in 5 wards.

It is not for the Mental Welfare Commission to recommend the use of any particular assessment tool, but we were struck by the variety of ways that care needs were being assessed. The majority of these post-admission assessments focused on physical health care needs which, although undoubtedly essential, highlighted the lack of ongoing assessment of mental health and social care needs that we would expect given the care groups.

We did not find any information stating why particular approaches to assessments were undertaken. Given the similarity of function between the wards visited, the lack of consistency in the approach taken to, and the quality of, assessment and care planning was very striking.

The introduction of the NHS Quality Improvement Scotland Integrated Care Pathway standards for dementia care will provide an opportunity to ensure best practice in assessment.

Awareness of National Clinical Guidelines

Dementia care is an area of practice that is well served by good practice guidance. The Scottish Intercollegiate Guidelines Network (SIGN) have produced two guidelines that have particular relevance to people with dementia and the staff who care for them. SIGN guideline 86(2006) relates to the management of patients with dementia and SIGN guideline 22(1998) relates to interventions for the management of behavioural and psychological aspects of dementia.

Given that a high proportion of patients in NHS continuing care units may display behavioural disturbances, we thought it was important that staff were aware of the guidelines and their recommendations relating to pharmalogical and non-pharmalogical interventions. We were disappointed to find that of the trained nursing staff we spoke to only 10 out of 16 areas had an awareness of SIGN 22 and 8 out of 16 had an awareness of SIGN 86.

Table 2

Information from patients

Wards		Named Nurse	Care Plan	Are all care needs met in CP	Life history	Likes/ Dislikes	Info from relatives	Unmet care needs identified
Dunrod	1	✓	✓	✗	✓	✓	✗	–
Dunrod	2	✓	✓	✗	✓	✗	✓	✓
Parkside	1	✓	✓	✓	✓	✓	✓	–
Parkside	2	✓	✓	✓	✓	✓	✓	–
CC1	1	✓	✓	✓	✗	✓	✓	–
CC1	2	✓	✓	✓	✗	✓	✓	–
Rosebery	1	✗	✓	✓	✗	✗	✓	–
Rosebery	2	✓	✓	✓	✓	✓	✗	–
Torvean	1	✓	✓	✓	✓	✓	✗	–
Torvean	2	✓	✓	✓	✓	✓	✓	–
Kinclaven	1	✓	✓	✗	✗	✗	✓	–
Kinclaven	2	✓	✓	✓	✓	✗	✓	–
Tate	1	✓	✓	✗	✗	✓	✗	–
Pavilion	1	✓	✓	✓	✗	✓	✗	–
Pavilion	2	✓	✓	✓	✗	✗	✓	–
Fruin	1	✓	✓	✓	✗	✗	✓	–
Fruin	2	✓	✓	✓	✗	✗	✗	–
Bayview	1	✓	✓	✓	✓	✓	✓	–
Bayview	2	✓	✓	✗	✗	✗	✗	–

Table 2 continued

Information from patients

Wards		Named Nurse	Care Plan	Are all care needs met in CP	Life history	Likes/ Dislikes	Info from relatives	Unmet care needs identified
19 Liff	1	✓	✓	✓	✗	✗	✗	–
Gordon V	1	✓	✓	✓	✗	✓	✗	✓
Gordon V	2	✓	✓	✗	✗	✗	✗	✓
3 B'bridge	1	✓	✓	✓	✓	✓	✓	–
3 B'bridge	2	✓	✓	✓	✓	✓	✓	–
Canaan	1	✓	✓	✓	✗	✗	✓	–
Canaan	2	✓	✓	✓	✗	✗	✓	–
Seaview	1	✓	✓	✓	✓	✗	✓	–
Seaview	2	✓	✓	✗	✓	✗	✓	–
Poynder	1	✓	✓	✓	✓	✗	✓	✓
Poynder	2	✓	✓	✓	✓	✓	✓	✗

We think that all patients in dementia care settings should have life histories available.

Use of life histories

A detailed personal history is an essential part of an assessment of any person with dementia.[2] These assessments usually involve discussion with the main carer or a person who can give accurate third person information. Over and above this assessment, the availability of a life history for care staff can greatly assist in planning care and in enhancing communication with the person affected by dementia. Staff knowing who they are looking after, their likes and dislikes, their background and some idea of their life history is essential to the provision of good care. Life histories can help in the understanding of the ethnic and cultural backgrounds of residents from minority groups. The recognition of the individuality of someone receiving care reduces the risk of institutional care practices. We were particularly interested to see if there was evidence of individual life histories available to the staff who were giving direct care. Half of the 29 patients whose records we examined had some form of life history. In general, staff were very positive about this approach. We think that all patients in dementia care settings should have life histories available.

Use of Restraint

Dementia can affect behaviour in such a way that it places the person concerned at risk and can sometimes be a risk to others around them. Effective management of that behaviour requires very careful assessment, to understand why the person is behaving in a risky manner and to determine how best to help reduce those risks. Sometimes risk reduction might involve care interventions that constitute restraint on the person's movement. The use of restraint in any setting requires careful control. Staff using any form of restraint should have clear guidance and local policies and procedures in place. The Commission has produced guidance on the use of restraint in its publication [3]Rights, Risks and Limits to Freedom. We took the opportunity to ask about the use of restraint and to ask staff about the availability of guidance and training in their areas.

In 12 of the 16 wards there was a policy in place regarding the use of restraint, with 11 wards having this readily available to view.14 wards indicated that mechanical restraint was used at times (mostly bed rails or lap straps), with 11 actually using some form of restraint at the time of the visit. It was concerning to note that training in restraint had been undertaken by staff in only 7 of the wards visited.

Of the 16 wards visited 2 did not have locked entry doors. 8 wards had a policy on locking the door. 3 wards had keypads that allowed capable persons to leave without asking staff.

[2] For examples see State of the Art in Dementia Care, M. Marshall 1997, London.

[3] Risks, Rights and Limits to Freedom. MWC 2006.

Physical Health Care

Regular physical health checks are essential for older people in continuing care wards. Many patients with dementia find it difficult to express discomfort or identify symptoms that may indicate physical illness. Recognising pain requires careful assessment and, of the 29 case records examined, 5 had no record of the last physical health check carried out and only 10 patients had evidence of a pain assessment tool in place. 1 person had a physical health check over 12 months before the visit with 4 taking place 6-12 months prior to our visit. 4 had a check 3-6 months before our visit with 16 having had a physical check within the 3 months prior to our visit.

Table 3

Nutrition

Hospital	Ward	Patients in ward at time of visit	Intensive assistance	Supervision	Total	% of patients requiring any assistance	Staff available at main meal
Stratheden	Bayview	9	1	6	7	11	4
Vale of Leven	Fruin	12	1	11	12	8	4
Kelso	Poynder View	14	9	5	14	65	4
Ayrshire Central	Pavillion 1	12	1	11	12	8	4
Gartnavel Royal	Tate House	21	3	18	21	14	5
Whyteman's Brae	Seaview	15	11	4	15	73	6
Murray Royal	Kinclaven	12	4	8	12	33	4
New Craigs	Torvean	12	8	4	12	66	4
Tippethill	Roseberry	28	14	7	21	50	5
Huntly	Gordon Villa	8	2	2	4	25	4
REH	Canaan	20	12	8	20	60	9
Bonnybridge	Ward 3	20	6	4	10	30	5
Rosslynlee	CC1	12	12	0	12	100	4
Ravenscraig	Dunrod F	22	8	13	21	36	5
Cleland	Parkside North	15	15	0	15	100	4
Liff	Ward 19	14	7	7	14	50	5

People in continuing care dementia wards are likely to be vulnerable and susceptible to under-nutrition and associated weight loss[4]. Eating is an important part of daily life. We were particularly interested to see if there was sufficient time support and the right environment for patients to enjoy their meals as a significant event in their day. Our visit gave an opportunity to ask questions about the arrangements for support and supervision at meal times and ask if staff felt they had the time to attend to this vital part of daily life of people living in continuing care wards.

Table 3 illustrates the degree of close support and supervision a large proportion of the patients in the wards visited require. In 7 of the wards visited it was reported that there were insufficient staff to help at mealtimes. One ward acknowledged that meals can go cold while staff try to attend to all of the patients. All of the wards recognized the importance of nutrition and some had rearranged staff meal breaks to provide sufficient resources.

In the 16 wards visited there was evidence that patients' weight was recorded, although it was hard to see in some cases how often this was reviewed and how it related to individual care plans. Of the 29 patients' records viewed 16 had had a dated record of body mass index. A dietitian was directly involved in 7 cases.

4 wards did not have separate dining areas, although not all staff saw this as a problem, particularly for patients who are highly physically dependent.

Only 2 wards had easy, open access to drinking water for patients. There was little evidence of individual fluid requirements specified in individual care plans.

Activities

Keeping physically and mentally active is very important for people with dementia in continuing care. Put simply, sitting still is bad for your health. Stimulating mental activities can help with orientation and memory. Of 29 patients case records that we examined there were a wide range of activities recorded. For 14 people, however there was no evidence of assessment for, or the provision of, any social or recreational activities in their care plans.

[4] Food, Fluid and Nutritional Care in Hospitals National Overview August 2006, NHS Quality Improvement Scotland.

Many staff commented on the need for more resources to provide a better range of activities for patients.

Activities mentioned in individual care plans (n=29)

Aromatherapy	1
Exercise	1
Hairdressers	1
Listening to music	5
Lunch Outings	1
Make up	1
Massage	6
Outings	2
Physical Games	1
Reading	2
Reminiscence	4
Shopping	1
Sing a longs	1
Walks	1
Word Games	2

Although staff reported wider availability of activities in some of the wards visited, we were disappointed at the relatively low emphasis on the encouragement of appropriate and stimulating activities for patients.

We were also interested in seeing how often patients have an opportunity to get outside the ward. Of the 29 records examined it appeared that 9 patients had not left the ward since admission. 4 had been out in the last 6 to 12 months, 2 in the last 3 to 6 months and 12 in last 3 months.

Many staff commented on the need for more resources to provide a better range of activities for patients. A recurrent theme was difficulties in accessing appropriate transport.

"... a better mini bus in which we could take patients out. The current bus has too high a step and that limits its use."

"The activities co-ordinator has made a huge difference to the quality of life of all the patients on the ward. She works with everyone ..."

"More staff would help. Tomorrow 1 registered nurse, 1 nursing assistant and 3 agency staff. We need OT and stimulation, our support worker presently has to cover basic care."

What will the Commission do next?

Dementia care is fortunate in that there are many sources of guidance and good practice available. We will press services to make the investment to improve facilities, to review the quality of their current services in light of guidance on good practice and enable staff to take a critical look at their care practices and seek out ways to improve the service they provide.

We will discuss the findings of our visit at our regular meetings with all of the services involved and discuss the issues raised with other relevant bodies such as NHS Quality Improvement Scotland.

Key messages for service providers

- The assessment and provision care for people in continuing care wards should be driven by need, not by resources. While adequate resources are essential not all improvements are expensive. Small changes can make big improvements to the quality of life for people living in continuing care wards.
- Staff want to provide excellent care in the right kind of environment but feel constrained by limited resources. Staff need support to improve existing care environments.
- Many of the wards visited did not provide information to patients and relatives in an accessible manner.
- The information available in all of the wards we visited was only in English.
- Relatives we spoke to were very positive about staff but thought that they should be able to spend more time with patients.
- Service providers should take a fresh look at the environment of their continuing care wards and use the extensive guidance available to see how their facilities match up to best practice standards.
- Methods of the assessment of care needs varied greatly between different wards providing essentially the same service. The introduction of the NHS Quality Improvement Scotland Integrated Care Pathway standards for dementia care will provide an opportunity to ensure best practice in assessment.
- Greater use of life histories would help in the assessment and provision of care and treatment.
- Nutrition and hydration are essential to care. Too many wards reported difficulty in making sure that patients are getting all the help they need with eating and drinking.
- Physical and mental activities for patients are valued by patients themselves, relatives and staff. However, options appear to be limited in many wards and too few patients are involved.

mentalwelfare
commission for scotland

Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Service user and carer
freephone: 0800 389 6809

enquiries@mwcscot.org.uk

www.mwcscot.org.uk