

Mental Welfare Commission for Scotland

Report on announced visit to: Lammerlaw Ward, Herdmanflat
Hospital, Haddington EH41 3BU

Date of visit: 8 May 2018

Where we visited

Lammerlaw Ward is a 16-bedded mixed inpatient, complex care ward for older people with a diagnosis of a dementia. The ward is the only inpatient service remaining on the Herdmanflat hospital site. We last visited this ward on 24 January 2017 and made a number of recommendations related to care planning, documentation, access issues on the ward and personalisation of the environment.

On the day of this visit we wanted to follow up on the previous recommendations. We also wanted to explore any issues raised by patients, carers or staff about patient care, due to recent complaints shared with us about care on the ward.

Who we met with

We met with/or reviewed the care and treatment of six patients, and received feedback from five carers/relatives/friends.

We spoke with the service manager, charge nurse and members of nursing staff.

Commission visitors

Juliet Brock, Medical Officer

Paula John, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

Staffing

We heard mixed views from families about the care and treatment offered on the ward. Although carers told us they felt welcome on the unit, there were mixed views about staff responsiveness and the level of care provided to patients. Some relatives raised concerns which we are following up directly with the service.

We learned from senior staff at the outset of this visit that the last year has been a challenging time. Staffing had again been a significant issue, with high levels of staff sickness, members of staff leaving and difficulties recruiting new members of the team. At times, arranging short term cover from the staff bank has also proved a challenge. We were told that staff morale was low. We explored the possible reasons for these difficulties and the challenges that staff shortages currently present: for the team, for patients and for carers.

We were told that following complaints from a number of carers last year, a senior manager was brought in to review and manage the service. An audit of clinical practice on the ward was then commissioned, and this made a number of recommendations. An improvement plan is now underway and the team are being supported to implement this.

At the time of our visit, staffing continued to be a problem although recruitment was underway for a number of new posts.

The team comprises a consultant psychiatrist, nurses and health care assistants. A local GP visits three times a week to review patients' physical health and provides additional telephone consultation when required. We were advised that the occupational therapist (OT) post is currently unfilled.

Weekly consultant ward rounds take place in addition to monthly team meetings, with additional input from a pharmacist.

Support from other health professionals can be arranged on a referral basis. This includes consultation from speech and language therapy and physiotherapy. When support for managing stressed and distressed behaviour is required, the consultant refers to the East and Midlothian Psychological Assessment Team (EMPAT).

Care planning

When we last visited, we made recommendations to improve and audit care plans. Although some review work has taken place since, we found care plans to be of variable quality, with only some content personalised. At times we could not find appropriate care plans, for example to look at the mobility needs of an individual at risk of falls. We were also concerned by the lack of risk assessment information in some files we looked at, particularly around physical risks such as falls for individuals who were frail.

We found documentation overall to be of variable quality. Multidisciplinary reviews were printed on coloured paper making them easy to find and were generally well completed. Individual life history information on forms such as "My life so far", were only partially completed in some cases.

Recommendation 1:

Managers should carry out regular audits of all casefiles. Particular attention should be given to ensuring there are person-centred care plans, life history information and comprehensive risk assessments completed for every patient.

During the last visit we had concerns about the absence of welfare proxy consent on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms for some patients. We were pleased to note improvements on this visit, with the forms fully completed in the files we reviewed. We were told that the consultant psychiatrist now takes responsibility for the completion of these documents.

We were pleased to hear about a monthly friends and relatives meetings on the ward. This group was set up by a carer, and provides an opportunity for carers to meet informally. The charge nurse and staff are invited to attend. We heard that their attendance is valued, as is their willingness to answer questions the group have.

Use of mental health and incapacity legislation

We found relevant copies of documentation as required under the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under s47 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 AWI Act.

All patients had appropriate s47 certificates to authorise their medical treatment. These were accompanied by personalised treatment plans. These documents were completed by the consultant and were filed alongside drug prescription sheets, where they could be easily referred to.

Where covert medication was being used, we found appropriate documentation and care plans with reviews.

Rights and restrictions

During our last visit, we commented on the lack of accessibility for patients to both their bedroom areas and quiet lounge during the day. We recommended that the locked door separating these areas be reviewed.

We were pleased to note on this visit that the keypad system, which previously acted as a barrier, had since been removed. Patients can now access their bedrooms and the quiet lounge area independently. Staff told us this had been a positive change. They had also noted a benefit to ambulatory patients who enjoy walking and are now able to 'circuit' the ward unencumbered if they wish. The charge nurse commented that they thought the use of 'as required' medication had reduced since the doors were kept open. A relative also commented positively about the door being unlocked, noting that patients seemed "less stressed as a result".

Advocacy

We were told that patients had access to advocacy from the organisation EARS. However, we found no reference to advocacy in any of the files we looked at and there was no information displayed on the ward about this.

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/>

Recommendation 2:

Managers should ensure that information about independent advocacy support is easily accessible on the ward and that patients are supported to access advocacy as appropriate.

Activity and occupation

A number of carers raised concerns about the lack of stimulation and activities for patients on the ward.

We learned from senior staff that the activities co-ordinator had not been able to input regularly to the ward due to recent absence. Ward staff were trying to bridge this gap, but given shortages, a regular activity programme remained lacking. On the day of our visit, those patients who did not have visitors were watching television in the lounge for most of the day.

Staff told us they were implementing protected activity time, a strategy they had seen used successfully at the Royal Edinburgh Hospital. There were also plans to involve community resources such as Hearts and Minds, Elderflowers and a Therapony. We were told that a significant proportion of patients have limited verbal communication, making sensory activities an important part of delivering an appropriate activity programme for the inpatient group.

Recommendation 3:

Managers should ensure that a daily activity programme, appropriate to the patient group's needs, is available and accessible on the ward.

The physical environment

For some years now there have been plans to move Lammerlaw Ward to a new site at Roodlands Hospital. We were told that designs are now in place for the new unit, which will offer an open-plan environment with individual en-suite rooms for a larger patient group of 20. The new hospital at Roodlands currently offers outpatient clinics, and on-site OT and physiotherapy will be available when the ward moves.

Lammerlaw Ward is currently housed in an old building on the Herdmanflat site. Attempts have been made to update parts of the ward and offer a dementia-friendly environment. There is good signage and handrails around the ward. Interest is offered by pictures and sensory boards on the walls. Staff have worked with families to plan the re-decoration of the large dining room, with seasonal pictures and space for photographs of resident activities on the walls. The television lounge is light and spacious. Staff had recently purchased new recliner chairs for patients.

Most bedrooms are offered in dormitory accommodation. We noted some improvement in the personalisation of bed spaces, something also recommended in

our last visit report. Staff told us they were getting individual's photographs updated for bedroom doors.

The quiet room has also been recently refurbished and now offers a 'Rempod' movie room for patients to enjoy watching films with their families. The décor of the room is homely and inviting, and objects within it encourage reminiscence. We were told that families were involved in the design, helped raise funds and brought additions such as bunting and curtains. We were told that the space is well used by patients and families. Staff also said that they sometimes use this space as a bedroom for patients requiring end of life care, because it has an attached bathroom and is large enough to enable family members to stay with their loved one if they wish. Whilst well-intentioned, we thought this would be very confusing, both for patients and their families. It could also impact the otherwise positive associations the patient group have with this recreational space.

The ward has a garden space. It is a concreted area with benches and flowerbeds. We were told that families use the space, however there are concerns about patient safety, so it can only be accessed by individuals who are escorted. There was mention of involving Haddington in Bloom to improve the space.

Any other comments

We were informed by some carers that they only received the letter about our visit a few days before we arrived. As this visit had been planned with the ward over a month in advance, this was disappointing to hear.

Summary of recommendations

1. Managers should carry out regular audits of all casefiles. Particular attention should be given to ensuring there are person-centred care plans, life history information and comprehensive risk assessments completed for every patient.
2. Managers should ensure that information about independent advocacy support is easily accessible on the ward, and that patients are supported to access advocacy as appropriate.
3. Managers should ensure that a daily activity programme, appropriate to the patient group's needs, is available and accessible on the 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

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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