

Mental Welfare Commission for Scotland

Report on unannounced visit to: Pentland Ward, Royal
Edinburgh Hospital, Morningside Terrace, Edinburgh, EH10 5HF

Date of visit: 23 October 2018

Where we visited

Pentland Ward is a 14-bedded ward for men over the age of 65 with a diagnosis of dementia and who display stress and distressed behaviour. It 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. On the day of our visit, 13 of the 14 beds on the ward were occupied.

We last visited Pentland Ward in March 2016 on a joint visit with Jordan Ward. Jordan Ward was situated on the first floor of the Jardine Clinic, and cared for men over 65 with a diagnosis of dementia who also had complex physical health care needs. At that time, plans were being made to close Jordan Ward over a period of two years, with patients being transferred for ongoing care in other NHS continuing care settings or nursing homes. Jordan Ward closed in May 2018. Pentland Ward is currently the only ward housed in the Jardine Clinic.

When we last visited, we made recommendations about care planning, personalisation of patients' bed spaces, documentation relating to aspects of the Adults with Incapacity (Scotland) Act 2000 (AWI), and staff training.

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

Who we met with

We met with and/or reviewed the care and treatment of eight patients and met with one relative on the day.

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

In addition, we consulted with advocacy agencies following the visit, including Edinburgh Carers Council.

Commission visitors

Juliet Brock, Medical Officer

Ian Cairns, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

On the day of the visit we found a calm atmosphere on the ward. We observed caring interactions between staff and patients while we were there. The patients we met with were relaxed and content and the staff we spoke with had a good knowledge of the individual patients in their care.

We received positive feedback from a relative who felt that their loved one was well cared for, and that staff were particularly attentive to physical health needs, attending to any issues promptly.

At the time of this visit, patient notes were held in paper files. We were told that the ward would soon be moving to the online TRAK notes system, with plans for all local Mental Health for Older People's services to be online within three to six months.

We were pleased to see 'Getting to Know Me' forms present in the files we viewed. Several of these, however, included limited information. We realise that staff are reliant on relatives helping to complete these forms. As discussed on the day, we suggested that staff prompt relatives to complete the form, as it provides personal information to help the clinical team know more about the individual and how best to care for them.

In the care plans we viewed, we found some to be detailed and person-centred, with useful information about interventions to support the individual. Care plan quality was variable, with some providing limited information and having not been updated or reviewed for over a year.

We saw good evidence of attention to physical health needs, with support from a range of specialists recorded including dietetics, tissue viability, and oncology where appropriate.

We found good recordings of multidisciplinary team (MDT) meetings using the hospital's SCAMPER format, with attendance list, clear decision-making and action points recorded. Individual patients' three to six-monthly reviews were also well completed.

We found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and ceiling of care forms were well completed, with review dates where appropriate, and saw evidence of involvement of relatives in decision making.

As a general comment, we felt that patient files would benefit from better organisation and from outdated documents being filed in archived sets of notes. This will no doubt be part of the process when patient files switch to electronic format in the near future.

Recommendation 1:

Managers should ensure that care plans are person centred, individualised, and reviewed on a regular basis.

Use of mental health and incapacity legislation

For those patients subject to the Mental Health (Care and treatment) (Scotland) Act 2003 (MHA), we found copies of appropriate documentation on file. For individuals subject to AWI, it was unclear in some cases whether there was a power of attorney or welfare guardian in place. When we asked staff about this there appeared to be some confusion. When we did find information, it was often misfiled.

We found copies of 'consent to treatment' (T2) and 'certificates authorising treatment' (T3) forms appropriately filed, with patient prescription sheets where MHA authorisation to treat was required. We also found old T3 forms accompanying the drug prescription sheets for a few patients who were no longer detained. This could be confusing for staff. We suggested to senior staff that the ward files were updated, and to remove all documents that were not current.

Patients who lacked capacity to consent to their care and treatment had Section 47 certificates in place in accordance with AWI legislation. Some s47 certificates were accompanied by appropriate treatment plans detailing the medical conditions for which the patient required treatment. There was confusion about the expiry date of patients' s47 certificates on the ward office noticeboard. We brought this to the attention of staff so that it could be corrected.

Recommendation 2:

Managers should ensure that powers of attorney and welfare guardians are identified on the front page of care notes and held in a consistent place within the file.

The Mental Welfare Commission has published a quick guide for staff on Power of Attorney https://www.mwcscot.org.uk/media/241253/poa_leaflet_care_homes.pdf. We recommend that a checklist is used for people who have a welfare guardian or power of attorney, as a record of how the guardian or attorney wishes to delegate powers (if at all). An example of such a checklist can be found in this guide https://www.mwcscot.org.uk/media/51918/working_with_the_awi_act.pdf.

Rights and restrictions

Many patients appeared to be receiving medication covertly. Appropriate forms had been completed but most of these had not been reviewed since 2016/17. We discussed this with staff and asked that all covert medication be reviewed, and forms updated where this was still required.

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

When we viewed patient records we saw little evidence of activities being recorded. We were told there were plans to improve this.

We heard from the staff team that there had been a number of recent changes impacting on activities on the ward. Previously, patients on Pentland Ward had joined Canaan Ward patients for group activities. We were told by staff that this had worked well. Since Canaan Ward relocated to the new Royal Edinburgh Building, it has been less easily accessible and we were told that the joint activity programme had reduced as a result. Patients from both wards do, however, still attend a monthly dance at a local miners' club and partners are encouraged to join this outing.

We were told that the ward previously had a full-time activity nurse and that this enabled more individual work and the organisation of away days. At present, ward staff undertake 'activity shifts' a few times a week, working with patients either individually or in groups.

Staff told us that dedicated time was now being provided from occupational therapy for patients on Pentland Ward. There is also input to the ward from music therapy. However, we could not see an activity timetable visible on the ward to help orientate patients to these activities in their routine.

We were told by managers on this visit that a plan was in place to recruit a new activity co-ordinator and that this would take place in November 2018. We look forward to seeing progress in activity provision with this new post on future visits.

The physical environment

On the day of our visit we found the main corridor on the ward to be rather gloomy and dimly lit. The overall decor was also in need of some general upgrading (we noted for example patches of bare plaster in one of the bedrooms). There were some items of visual interest on the corridor walls but, again, this would benefit from further improvement (for example a Pentland Ward 'memory tree' feature had been removed from the wall, with only the title remaining). There was dementia-friendly signage in the corridors. There was no visible timetable or noticeboard with information to assist patients with daily orientation. We discussed this with managers on the day and were assured that this addition would be made.

The ward provides individual bedrooms for patients, with two larger assisted bedrooms for those with physical disability. All but two bedrooms are en suite. We noted that some patients and their families had personalised their rooms with pictures and mementos.

The main communal areas on the ward are the lounge and dining room. We found the large patient lounge to be rather stark and uninviting, with little interest or warmth in the decor or furnishings. The service manager acknowledged that some general improvements were needed and advised us of plans to reconfigure and refurbish the ward, including introducing a dementia-friendly café space for patients and relatives in the lounge area.

We were told that work will be dependent on funding to upgrade the building. We were informed this funding would be linked to the planned relocation of Liberton Hospital's continuing care ward to the Jardine Clinic. We were advised that the plans include reconfiguring Pentland Ward to a 15-bedded unit. The timescale for this is not yet confirmed and we would want to be kept updated on this by managers.

Pentland Ward has direct access to a large private garden area from the dining room. The garden has mature planting and incorporates areas to sit with raised beds and other features of interest, including an enclosed area housing chickens, which are looked after by the ward. A recent stunning addition has been a wooden geodesic dome, offering a sheltered seating area in the centre of the garden space. We heard that this construction was designed and made in collaboration with Artlink and that the structure was hand built by a member of Artlink and a patient on the ward. This remarkable project is documented in photographs on a display in the dining room.

We heard from staff how this build, which took place over a matter of months, had greatly benefitted the individual and had since been enjoyed by patients and families as a sheltered place to enjoy the surrounding garden.

Any other comments

We heard that some relatives had expressed concern about the visibility of staff on the ward. It was thought this may be due to the design of the ward (when staff are assisting patients in their rooms they may be some distance from the communal area). We were told this can create anxieties for visiting relatives about patient care and safety.

There are weekly meetings for all patients to review cases of delayed discharge. When patients no longer need care and treatment on Pentland Ward, transfer to a more appropriate setting is sought and may include nursing home care, care at Ellen's Glen for frail elderly people, or hospice care if required.

Summary of recommendations

1. Managers should ensure that care plans are person centred, individualised, and reviewed on a regular basis.
2. Managers should ensure that powers of attorney and welfare guardians are identified on the front page of care notes and held in a consistent place within the file.

Good practice

The Artlink collaboration with Pentland Ward is a great example of a creative project that can engage individuals with dementia, bring their skills to life, and provide an opportunity for enjoyable and meaningful activity.

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

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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