



Mental Welfare Commission for Scotland

Report on announced visit to: Prospect Bank Ward, Findlay House, 5 Seafield Street, Edinburgh, EH6 7LN

Date of visit: 26 November 2018

Where we visited

Prospect Bank is a 30-bed NHS continuing care ward for older adults with chronic and enduring mental health needs. The majority of patients on the ward have advanced dementia. Prospect Bank is one of two NHS continuing care wards that comprise Findlay House, a single-storey unit based on the former Eastern General Hospital site. The building is owned and managed by Robertson's as part of a PFI initiative, with meals and laundry services provided by NHS Lothian.

Prospect Bank is one of four national demonstrator sites currently participating in The Specialist Dementia Unit Improvement Programme, a Healthcare Improvement Scotland (HIS) initiative. Information on the project can be found at <https://ihub.scot/improvement-programmes/focus-on-dementia/specialist-dementia-units/>

We last visited this service on 7 July 2015, and made recommendations relating to increased activity provision, and for information relating to welfare proxies to be better documented in patient notes.

On the day of this visit we wanted to meet with patients and visitors, follow up on the previous recommendations, and to find out more about the developments underway via the improvement pilot.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and spoke with six carers, relatives, or friends.

We met with the senior charge nurse, charge nurse, activities co-ordinator, and other members of the staff team. In addition we met with a representative from Edinburgh Carers Council, and with one of the specialty doctors who support the ward.

Commission visitors

Juliet Brock, Medical Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

At the time of our visit there were 19 patients on the ward.

The feedback we received from carers and patients was generally very positive. Family members told us that staff were caring, approachable, and maintained good communication with them about their loved one's care. The positive feedback

extended throughout the team from nursing to medical staff. Where individual issues were raised by relatives, we spoke with staff about these on the day.

The multidisciplinary team consists of nursing staff, the consultant psychiatrist, two specialty doctors who provide daily cover to the wards, an occupational therapist (OT), OT assistant, and a full-time activity co-ordinator. Input from physiotherapy, a dietician, speech and language therapy, and dental and podiatry services can be arranged on a referral basis. There is also weekly input from a pharmacist.

When we visited, the service was hoping to appoint a psychologist early in 2019. It was anticipated that the post would be shared with Willow Ward at Ferryfield House. Funding had been allocated for this post.

Documentation

In the case notes we reviewed, we found the documentation to be of a good standard. "Getting to know me" forms were present. Care plans we viewed had a good level of detail, and were person centred and regularly reviewed. Weekly ward rounds were well documented, and reviews of medication and physical health issues by medical staff were clearly recorded. Risk assessments were also present in notes we reviewed. Documentation of three-monthly reviews indicated that relatives were invited, and were involved in discussions about an individual's care and treatment.

Participation in activities was not clearly evidenced in patient notes. We heard from the team, however, that this aspect of documentation was under reviewed.

Where decisions had been made regarding resuscitation, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were present, appropriately authorised, and had been discussed with the patient and/or nearest relative/welfare proxy.

We were told that all staff had received stress and distress training based on the Newcastle Model, and that updates continued to be run by a member of staff.

As a result of the ward being selected as a pilot site for the HIS dementia care programme, the staff team had identified three areas for improvement: activities, mealtimes, and the environment. The team's work across these three domains is discussed in the activities and environment sections of the report.

Carer support

Relatives meetings and a carer support group on the ward are facilitated by staff. The representative we met from Edinburgh Carers Council (ECC) told us that carers are well supported by the team and that feedback is positive. The ECC provide additional support for individual carers when this is required.

Use of mental health and incapacity legislation

Where patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act), we found copies of Mental Health Act paperwork filed in their notes. At the time of our visit we found that among three patients for whom consent to treatment certificates (T2s) or certificates authorising treatment (T3s) were required to authorise treatment under part 16 of the Mental Health Act, only one was in place. We discussed this with senior staff on the day for urgent review.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 Act (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. When we viewed patients' prescription charts, we found that AWI Act s47 consent to treatment certificates were present, along with accompanying care plans.

Recommendation 1:

Ward managers must ensure that, when patients are being treated under part 16 of the Mental Health Act, consent to treatment certificates (T2) or certificates authorising treatment (T3) are in place where required.

Rights and restrictions

We found that in cases where an individual did not agree to stay on the ward, but their limited mobility meant they were unable to leave, the Mental Health Act had been appropriately used to safeguard their rights.

We were told that 17 of the 19 patients on the ward during our visit presented a falls risk, and two patients were being nursed on an enhanced level of observation. Where patients had been placed on enhanced levels of observation for their safety, we found that this was being regularly reviewed.

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

We found a significant improvement in activity provision on the ward since our last visit. The appointment of a full-time activity co-ordinator appeared to have transformed this aspect of patient care. Activities had also been a key focus identified by the team for improvement in the dementia pilot.

The activity co-ordinator had been in post for six months when we visited. Working closely with the OT team, the activity co-ordinator was carrying out joint assessments for each patient and tailoring activities to suit their needs. By completing the “getting to know me” document with the person’s family, this also helped inform an activity programme for each individual. Pool activity level assessments were underway for a number of patients as part of the quality improvement pilot.

The team told us they had found that this individual approach, and the provision of one-to-one activities, has been of more benefit to the patients than providing a timetable of group activities for the ward as a whole.

The activity co-ordinator had linked in with a range of third sector organisations to provide a wide variety of activities. These included Artlink, Music for Hospitals, Elderflowers, Reading Friends (volunteers who sit and read to patient) and visiting Therapets. Art sessions were also organised for individuals or small groups on the ward, and singing sessions and concerts were held regularly. We were told that funding had been made available for a number of seated dance sessions on the ward to be facilitated by Dancebase, who would also train staff in this method. The team were also hoping to recruit a volunteer to offer regular gardening sessions with patients.

We were told that nurse-led interactions were also a key focus, offering informal activities such as garden walks, games, and reminiscence. Individuals who were bedbound, or whose mobility was severely restricting, were being supported by staff to take part in activities where possible.

The ward had Playlist for Life, and the activity co-ordinator and OT were working to compile playlists for patients.

Spiritual and religious support was available to those who wanted it, with visits arranged on request.

The physical environment

The ward design incorporates three bedroom corridors radiating from a central atrium. Seats around the atrium provided a place for patients to sit and watch the comings and goings of the ward. There was a bus stop and bench situated in one of the corridors which offered another space, popular with patients, to sit and talk.

Located across the three corridors (two female and one male) are 27 bedrooms. Each bedroom has an en-suite toilet and washbasin. A shared bathroom is provided in each corridor. Staff explained that patients had individualised bathing routines according to their personal needs and preferences.

We found the bedrooms were bright, comfortable, and in good decorative order. Patients were able to personalise their space with pictures, photographs, and other

personal items. A noticeboard in each room provided information to help orientation, and care-rounding documents were kept in patient folders.

The communal areas in the ward included a small dining room and a large lounge. An enclosed garden area, accessed from the lounge, could be used independently by patients. This outside space provided seating areas, and points of visual interest with a gazebo and planters. It was planned that Artlink would involve patients in garden projects during warmer months.

With the environment highlighted as one of the key areas of improvement in the dementia pilot, the team talked about a range of plans to improve the ward and make the space more dementia friendly. Having used a dementia design audit tool to review the ward environment, they had secured funding for redecoration to support wayfinding and to improve signage. There were plans to redecorate all the communal spaces on the ward.

We were also told of plans to convert an old kitchen outside the ward into a dementia café for patients and relatives to use. At the time of our visit this was at the stage of awaiting architect plans. The smaller, little-used, reminiscence room off the ward was also to be re-purposed to a relatives' room, providing a sofa bed for relatives to stay when required. We were told that patients' families were involved in the re-design of this space.

A number of carers commented to us that the ward can be busy and noisy at times. The staff team also raised this as a problem. They had begun to address the issue as part of improvement measures on the ward. The staff had carried out a piece of work to investigate noise levels, and had observed that patient distress appeared to be associated with heightened noise in different spaces. They identified, for example, that mealtimes in the small dining area were a particular problem. As a result the team had introduced simple but creative strategies to address this: they purchased different tableware (which was quieter to use) and introduced a new system for mealtimes. This encouraged patients who preferred having meals in their rooms or other areas of the ward to do so, with support. Staff told us this had led to a calmer, more relaxed atmosphere during meals. This flexible, person-centred approach meant that patients were able to eat where they preferred and staff could continue to support them, monitoring food and fluid intake where required.

The team told us they were still taking steps to monitor and address noise issues, and had recently applied for a grant to purchase noise-absorbing pictures for the ward.

One relative wondered whether patients might have a lockable place in their room to store particularly sentimental belongings, which may occasionally be moved by other patients. We suggested this to staff on the day as something the team might consider.

Any other comments

Given the ward environment, and in particular the issues with noise, it was difficult to envisage the unit functioning at full capacity with 30 inpatients. It is our experience that wards with 20 patients or fewer are generally calmer and quieter for people with dementia, particularly at this stage of their illness.

We were told that due to staffing shortages, bed numbers had in fact been capped by managers. Senior staff advised us that there were nine registered nurse vacancies at the time of our visit.

We were told there had been difficulties recruiting for a number of years, the main issue being identified as one of geography, and a lack of access to public transport. The local area is served by a single bus route, with reduced services at weekends. This presents a significant problem for staff who do not drive. It is also a challenge for relatives who rely on public transport to visit. We were advised that the issue had been highlighted with managers at NHS Lothian, however it is a matter largely outwith NHS control.

Despite these staffing challenges, we observed on this visit that the team appeared cohesive, knowledgeable about the patients in their care, and responsive to their needs.

Good practice

As described above, we found that the staff team were developing innovative approaches to address some of the environmental challenges on the ward. The quality improvement work around activities also demonstrated the team's commitment and thoughtful approach to providing an engaging and meaningful day-to-day experience for patients on the ward.

Summary of recommendations

1. Ward managers must ensure that, when patients are being treated under part 16 of the Mental Health Act, consent to treatment certificates (T2) or certificates authorising treatment (T3) are in place where required.

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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