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VISIT AND MONITORING REPORT

Making progress: older adult functional assessment wards

October 2015

Contents

What we do

We protect and promote the human rights of people with mental health problems, learning disabilities, dementia and related conditions.

We do this by:

- Checking if individual care and treatment are lawful and in line with good practice
- Empowering individuals and their carers through advice, guidance and information
- Promoting best practice in applying mental health and incapacity law
- Influencing legislation, policy and service development

Introduction

This report details what we found when we visited the twenty four NHS wards providing acute assessment for older people with functional mental illness in Scotland. It contains recommendations we have made to improve patient care.

Functional mental illness includes common conditions such as depression and anxiety, and rarer conditions such as schizophrenia, delusional disorder, bipolar affective disorder and obsessional compulsive disorder.

They are considered distinct from dementia, although people may suffer from both. The most common condition is depression which affects up to one in five older people living in the community, and up to two in five older people in care homes. While most functional mental illness will be successfully treated in the community, some older people will need inpatient treatment as they can be severely unwell, and may have existing physical health problems that complicate their care and treatment. They may spend several months in hospital.

We reviewed the care of 128 individuals, attempting to hear their views where possible, and spoke to 15 unpaid carers – most often family member or close friends.

Key findings

About a third of patients were receiving compulsory treatment under mental health legislation.

Clear care plans for mental health needs were found for nearly all patients. About a quarter of these care plans were felt to have a good amount of individualised and personalised content, with just over half having some individualised person centred content. The rest had non-individualised generic content.

Ninety seven patients were able to give information about staff availability; nearly all said staff were easily available and approachable.

Ninety patients were able to give information on how often they spoke to nursing staff. Over three quarters said they were satisfied with how often they spoke to a nurse.

Thirteen of the 15 family members or carers we spoke to said that they always felt welcome on the ward, with the remaining two feeling welcome sometimes. All the carers felt that the staff on the wards treated them and patients with dignity and respect. Two thirds felt involved in care decisions on the ward.

Just under half of the patients we met had an individual activity care plan or individualised activity profile in place. Of these, just over three quarters included person-centred information about the patient's activity interests and abilities.

Nearly all patients were being reviewed at least weekly by their psychiatrist, with the remainder being reviewed every fortnight.

There was considerable variation in levels of input from clinical psychologists in different wards.

The completion rate of T2 and T3 forms authorising treatment was very high.

There was a high completion rate of section 47 certificates authorising treatment, and the majority of these were well completed, in accordance with the Code of Practice.

Of the 24 wards visited, 15 had a locked door at the time of the visit, and nine wards were unlocked. Four wards that were locked had no locked door policy.

Of the patients who were not detained, most felt free to come and go without restrictions. The majority of those who felt restricted had either agreed to be accompanied by staff when off the ward, or needed help due to physical problems.

Only about half of patients said they had access to advocacy, half were either unaware of, or did not have access to, advocacy. Detained patients were more likely to be aware of advocacy.

All but a single patient felt safe on the wards.

Most patients said there was somewhere private for them to meet visitors. A few said they did not receive any visitors, and some said there were no private visiting facilities.

Only a third of wards had arrangements for all patients to be able to keep possessions in their own locked drawer or cabinet, or to lock the door of their single room.

Almost a third of wards did not have easily accessible, safe, garden areas.

Recommendations

Care should be based around a person-centred care plan which addresses the needs of the patient. This should be regularly reviewed and updated and should include the views of the patient where possible.

Services should review the current activity provision on each ward to ensure that:

- **All patients have an individual recovery-focussed activity plan which identifies suitable activities based on the patient's skills, interests and current abilities. The use of appropriate recovery-focussed tools should be promoted.**
- **Staff at all levels have the skills and confidence to provide activities which reflect the interests of the current patient group.**
- **These activities - some of which will be one-to-one work - should take place during the day, evenings and at weekends and the activity timetable should be advertised clearly on the ward. Each person on the ward should know how to access them.**

Clinical psychology input should be available to meet the needs of patients. Part of each individual's assessment should include consideration of whether they would benefit from individual input from a clinical psychologist. If need for this is identified, this should be arranged. Ward teams should have psychology input to support staff in the development and delivery of psychological interventions.

Every unit that has, or may have, a locked door should have a policy in place that ensures the safety of, and respects the rights of, the individual patient.

Services should improve the provision of information for patients, to ensure that they are informed and kept aware of their right to advocacy.

The right to privacy, dignity and family life should be respected. All patients should be able to have private space, be able to make calls in private, and have a private area to see their family and friends when visited, unless there is significant risk to either themselves or others.

Wards should have appropriate arrangements in place to allow patients to safely bring some personal possessions into the ward.

Functional assessment wards for older people should be enriching therapeutic environments, conducive to an individual's recovery. Wards should be well-

maintained. People should feel comfortable and able to maintain privacy and dignity while in hospital.

Hospitals should ensure that there is easy access to a pleasant, safe and secure outside area.

Why we visited

For older people with functional mental illness, the care and treatment they receive in hospital is crucial to their ability to return to independent living as soon as possible. They should receive care and treatment which is high quality, individualised, recovery focussed, properly authorised and which takes place in an environment suitable to their needs. We last undertook a themed visit to older adult functional assessment wards in 2010, and you can read our findings in our report "*Where do I go [1]from here*?" [1] We wanted to see what improvements had been made since then.

Although the 2010 report also included the care of those with dementia, many of the key findings were relevant to the care of individuals with functional illness. Key messages in our 2010 report included:

1. People's freedom should be respected as far as possible when they are in hospital. There must be clear and regularly reviewed procedures in place when limits are placed on freedom.

2. People who lack capacity to consent to medical treatment should receive treatment that is in line with the law, and have their capacity to consent regularly reviewed.

3. The right of access to advocacy extends to everyone with a diagnosis of mental ill health, not just to those subject to compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003.

4. Assessment wards must provide opportunities for stimulation through physical and therapeutic activities, inside and outside the ward, which suit the individual's needs preferences and capacities. The main considerations when selecting and providing activities are knowing the person and matching the activity to the person's level of ability and interests.

5. All wards must provide a safe, stimulating and enabling environment both indoor and outdoor that respects the privacy and dignity of the individual.

[1] http://www.mwcscot.org.uk/media/53275/Where%20do%20I%20go%20from%20here%202010.pdf

How we carried out the visits

We identified all psychiatric wards in Scotland with acute functional beds for older adults. There were 24 wards over 23 sites. Four of these wards were designated mixed functional and dementia assessment; these were in Fife and Lothian.

We visited all twenty four wards between October 2014 and February 2015. We met with, and looked at the care of, 128 patients. We also spoke to 15 carers. Where we had concerns about the care and treatment being provided, we raised any issues with the nurse in charge on the day. Where necessary, we followed this up as casework.

After the visit, we sent a feedback letter to the ward manager for each ward providing some early ward-specific feedback.

We wanted to meet patients who had been admitted for assessment and treatment of functional illness rather than for dementia. We thus did not include patients who had been admitted primarily for the assessment and treatment of dementia. However, if the patient was admitted for assessment of functional illness concurrent with pre-existing dementia, or dementia was diagnosed during admission for assessment of functional illness, they were included.

All 24 wards were mixed sex, although one was nominally split into distinct male and female areas. Ward sizes ranged from six to 30. There were a total of 406 beds across the wards. When we visited, 90% of beds were occupied and 13 wards were fully occupied. Sixty three per cent of patients in the wards were women. In each of the wards we interviewed a senior member of nursing staff, and assessed the environment.

One hundred and twenty eight patients were reviewed. Of those, 100 (78%) engaged with the structured interview and answered questions, but not all patients could answer all questions. Twenty eight (22%) were entirely unable to do so due to their mental state.

We gathered information from the case notes of all individuals, and spoke to staff about them. Seventy seven (60%) were female, and 51 (40%) were male. One hundred and eleven (87%) described themselves as white Scottish, and a further 10 (8%) as white British. There was one person from each of the following ethnic groups; Russian, Iranian, Ukrainian, Spanish, Portuguese, Caribbean and Irish. We met the Russian national with an interpreter, who we were pleased to learn had been regularly involved in ward review meetings.

One hundred and twelve (87%) were aged 65 or older, 15 (12%) were aged 85 or older, and one patient was younger than 65. This individual was aged 63, and had been intitially admitted to an acute adult ward, then a decision was made to transfer the patient for more appropriate assessment.

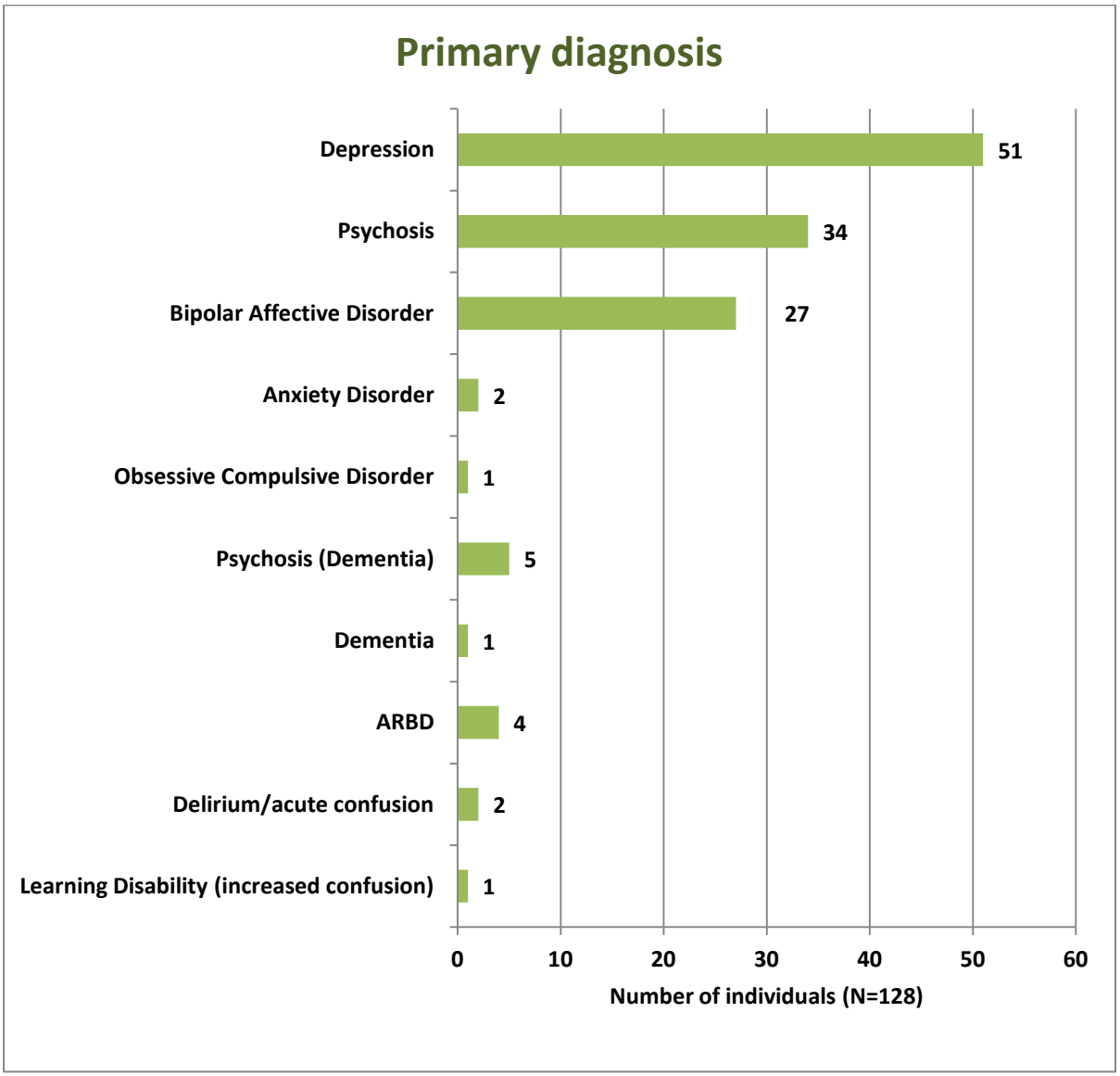
Forty six (36%) patients were receiving compulsory treatment under mental health legislation.

Forty five patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Thirty one of those were on Compulsory Treatment Orders, 13 were on Short-Term Detention Certificates (STDC), and one was on an Interim Compulsory Treatment Order (ICTO).

One individual was detained under a Compulsion Order with Restriction Order, under the Criminal Procedures (Scotland) Act 1995.

We established each patient's primary diagnosis from their medical records. These are shown in Figure 1. The category "psychosis" includes schizophrenia, schizoaffective disorder and delusional disorder. We have categorised five people as having "Psychosis (Dementia)". These individuals were admitted with psychosis that was linked to dementia. Where an individual had a mixed anxiety and depressive disorder, we included this within the category "Depression". ARBD stands for alcohol-related brain damage.

Figure 1



Engagement and participation

What we expect to find

All patients should have a clear individualised care plan that is regularly reviewed and updated. There should be evidence of their involvement where possible. There should be regular input and communication with family and carers.

What we found

Care planning

Clear care plans, for mental health needs, were found for 119 (94%) patients. About a third of the care plans were felt to have a good amount of individualised and personalised

content, whilst about half had some individualised, person-centred content. The rest had non-individualised generic content. Examples of good practice we found were:

Our comment – ward A

> *"Care plan for depression/psychosis/agitation. Clear goals with strengths identified and personalised interventions. Strong emphasis on self-hygiene, and guidelines for this. Recovery plan also completed, with individual's signature. Care plan interventions include 1:1 time with staff and these are recorded in continuation notes."*

Our comment – ward B

> *"Care plans are good. Evaluations are person centred, reviewed weekly and in detail. All aspects of the care plan are reviewed e.g. care plan relating to participation in ward activities - expected outcomes - increase self confidence and self esteem, reduce social isolation. Four ways identified of how best to manage that (two of these relating to previous activities). Everything dated and signed, which makes progress easy to track."*

Unfortunately in a number of care plans there was little sign of a person centred approach. In these cases, a generic care plan including a statement such as:

> "*An assessment of mental state"*
>
> *"Monitor his mental health"*

Care plans written in this generic style, with no other supporting information or detail, no goal setting, no instructions or guidance for staff on what was being measured, and no indication of how the staff or the individual would know if the goals had been achieved, were seen in a number of files. This is not acceptable.

When care plans lacked detail or depth, and when there was an absence of a review process, this was reported to staff on the day and in a follow-up letter.

Recommendation

Care should be based around a person-centred care plan which addresses the needs of the patient. This should be regularly reviewed and updated and, should include the views of the patient where possible.

Interactions with staff

What we expect to find

Patients should feel comfortable about approaching staff, and staff should be easily available.

What we found

Of the 97 patients who were able to give information about staff availability, 87 (90%) said staff were easily available and approachable, four (4%) said they were not, and six (6%) said they did not know.

It is good that a high proportion of patients find staff are easily available and approachable.

Most comments we received from individuals reflected appreciation of staff being caring and responsive. We recognise that it can be difficult for staff to remain easily available at times when clinical demands are high, and that nursing teams work hard to be available.

Patient's comment:

> *"Always easy to get the staff when I want to. They'll come to my room if I want a private talk."*

Patient's comment:

> *"It is not always easy to get someone to talk to. They are always busy doing other things. No-one makes an individual approach to me to ask me how I am, and just give some time in the day for me. The motivation to talk to someone has to come from me, not them, and when you are not feeling great that's not good."*

Of the 90 patients who were able to give information on how often they spoke to nursing staff, 71 (79%) said they were satisfied with how often the spoke to a nurse, seven (8%) said they weren't and 12 (13%) said they did not know.

Patients' comments:

> *"The nurses talk to me throughout the day."*
>
> *"The nurses always ask how I am and how I feel I am doing."*
>
> *"The nurses always come and talk to you. There is a Named Nurse on each shift for each person, and they always come and see how you are getting on."*

It was clear from comments such as these that most patients find staff proactive in having discussions and maintaining communication with them. A small number of people made comments indicating that they did not feel that nurses were undertaking enough therapeutic work with them.

Our comment on patient's experience:

> *"She said the nurses are nice and are happy to chat but "just engage in general chit chat, there is nothing therapeutic going on, there is no real help."*

It is important that patients have regular one-to-one therapeutic sessions with nursing staff, ideally their keyworker, in addition to members of the nursing staff interacting with them frequently and proactively.

Family and carer involvement

What we expect to find

Family and carers should feel part of the care process.

What we found

Fifteen carers were interviewed: 14 were close family members (either a spouse or a child) and one was a friend. Thirteen (87%) said that they always felt welcome on the ward, with the remaining two feeling welcome sometimes. All the carers felt that the staff on the wards treated themselves and patients with dignity and respect. Ten (67%) felt involved in care decisions on the ward.

Family/unpaid carers' comments:

> *"Staff doing an excellent job. Mum is quite nippy, so they are very patient. Good communication with staff. Very proactive staff I can tell they care."*

> *"I get feedback from ward meetings on Thursdays or could attend if wanted. I've seen the doctor two to three times. Nurses give regular feedback. Feel listened to."*

Less favourable comments recorded by us from family/unpaid carers included:

> *"Biggest issue is lack of feedback. Lack of information between doctors/nurses and family. Lack of communication. Feel they haven't been told diagnoses. No doctors around when they want to speak to them."*

> *"Not told what is happening with medications and how these affect her."*

"First they heard what was happening was at review a month ago."

We feel that family and carers should be involved in significant care and treatment decisions, where appropriate.

Recovery and activity

What we expect to find

We expected to find individual recovery-focussed activity plans which identify suitable meaningful activities, and take account of the individual's previous skills, interests and current abilities. Activities play an important role in helping people maintain existing skills, alleviate boredom, boost confidence and gain relief from distress.

What we found

We found many positive examples of recovery-based practice. One senior charge nurse told us that:

"The expectation on this ward is that each person will become involved in activities, and have some structure to each day. I am clear that individuals who have depression, for example, are often admitted having lost the confidence/ability to structure their day. Simply offering medication and the company of nurses and other patients is not enough. Individuals have to learn again the benefits of setting themselves goals for each day, no matter how small, so the sense of purpose and then achievement will spur them on and give them confidence each day."

On that ward, both the patients and carers we spoke to appreciated this emphasis on activity.

One patient commented:

"You are expected to join in and try to get involved. You are expected to have a plan each day whilst you are here. When you arrive, these can be very small things, such as having a shower in the morning, but it feels good when you have achieved them. As you get better, you are expected to be involved in more things."

Ward-based activities such as arts and crafts, scrabble, playing cards, quizzes, baking, movie nights were all referred to as being appreciated and enjoyed by the people we spoke to. Getting off the ward to go to an onsite cafe or local shop was also highly valued.

However, overall, only 55 (43%) patients had individual activity plans. In 44 (79%) of these, there was a clear link between the interests and abilities of the individual and the activities available on the ward. This is good practice. About two thirds of people had activities available that were in keeping with their personal choices and abilities.

A number of patients spoke of their own unwillingness to join in any activity, particularly when first admitted to the ward. Encouragement to take part was seen in some wards as a necessary part of recovery.

Physical activity was repeatedly referred to by patients as being an activity which they appreciated being on offer. This could be going for a walk, going to the gym, taking part in a Tai Chi class or gentle exercise on the ward. Ward-based exercise was noted to be particularly important by one person we met who was not allowed off the ward.

Carer views

Of the 15 family members/unpaid carers we spoke to, four expressed their disappointment at the provision of activities on the ward.

One man told us that:

> *"There is nothing appropriate for my wife to do. On one occasion she went to a relaxation session in another building. When she got there, she was the only person there. A relaxation tape was played to her and she was left on her own. (He did acknowledge the staff have apologised for this but his wife had not gone back)."*

Staff views

A significant number of staff felt that activity was an area that could be improved. Dedicated activity co-ordinators were highly valued as they had protected time to engage patients in activities, and could not be drawn into nursing tasks or sent to another ward which is short staffed.

Recommendation

Services should review the current activity provision on each ward to ensure that:

- **All patients have an individual recovery-focussed activity plan which identifies suitable activities based on the patient's skills, interests and current abilities. The use of appropriate recovery- focussed tools should be promoted.**
- **Staff at all levels have the skills and confidence to provide activities that reflect the interests of the current patient group.**

- **These activities, some of which will be one-to-one work, should take place during the day, evenings and at weekends. The activity timetable should be advertised clearly on the ward and each person on the ward should know how to access them.**

Multi-disciplinary team (MDT) reviews

What we expect to find

We expect to find that regular MDT review meetings take place. There should be clear documentation of these.

What we found

Some patients had been admitted too recently for this to be applicable, so we reviewed 118 patients. MDT review meetings were held weekly for most of these individuals, 107 (91%) had had a MDT within the previous seven days, and 10 (8%) within the previous fortnight. Only one of these individuals had not had a recent MDT meeting.

We found clear individual records of MDT review meetings for 109 of these people (92%). This is good practice. Seventy nine (67%) were considered to contain a clear forward plan. However only 53 (45%) included a clear attendance list.

We saw some excellent examples:

Our comment:

> *"Very full - records all who attended. Easy to locate. Contains views of patient and plans for future in addition to progress with current treatment."*

We saw some examples of less good practice, including a number of cases where proformas designed for documentation of MDT meetings had not been fully completed.

Our comment:

> *"MDT forms are excellent but they are not filled in properly. Personal goals and seven day treatment plan not filled in, nor risks/strengths, nor client's point of view. No attendance list."*

Overall, we were pleased to see so much good practice. We suggest that MDT meetings should always be documented with a clear record of: attendance, review of care and treatment, decisions made, the ongoing treatment plan, patient views and action points.

Medical reviews

What we expect to find

Patients should have a review of their mental state at least weekly by their consultant or another psychiatrist.

What we found

The majority of people able to respond (96) said that they saw their consultant, or another psychiatrist, at least once a week.

Patients' comments:

> *"I see her once a week but she is in and out of the ward all the time. If you want to see her anytime, you can."*

> *"Once a week. I appreciate the opportunity to talk in-depth about how I am. I can see him more than that if need to."*

A small number of individuals felt they were not seeing their psychiatrist enough.

Patients' comments:

> *"He is always busy."*

> *"I only get 5 minutes and he asks the questions."*

We looked at the case notes of 126 patients. One hundred and nineteen (94%) were being reviewed at least weekly, with the remainder being reviewed every fortnight. We were pleased that almost all patients were being reviewed by their psychiatrist on a weekly basis.

Psychology input

What we expect to find

Psychology can have an important role in the treatment of functional mental illness in older people, both directly, with the patient, and by supporting nursing staff to deliver therapy. We would expect that all assessment wards have timely access to psychology input.

What we found

Nurses reported considerable variation in levels of input from clinical psychologists for individuals in different wards. In some wards there was dedicated psychology provision, or nurses said that people were seen by a psychologist promptly after referral.

Our comments:

> *"Psychology respond to referrals quickly. No real wait response during in-patient stay is good."*

> *"Have half day psychologist each week. Peer support worker also."*

Staff in other wards spoke of slower response to referrals, or lack of psychology provision for inpatients.

Our comments:

> *"Poor access to psychology department. Never saw a psychologist on the ward."*

Recommendation

Clinical psychology input should be available to meet the needs of inpatients.

Part of each individual's assessment should include consideration of whether they would benefit from individual input from a clinical psychologist. If need for this is identified, this should be arranged.

Ward teams should have psychology input to support staff in the development and delivery of psychological interventions.

Respect for the rights of individuals

What we expect

Where required, we expect that a T2 form (where a patient is consenting to medical treatment) or a T3 form (where the patient is not consenting) is in place. We expect that advocacy services are available and being proactively used to ensure that patients are supported to participate in decision making. We expect that, where wards have locked doors, there is a locked door policy which explains how access to, and exit from, the ward are controlled. If a patient is telling staff that they do not wish to stay, or are making purposeful attempts to leave, we would expect to find that consideration has been given to use of the Mental Health Act.

What we found

Treatment under the Mental Health Act

- Forty five individuals were detained under the 2003 Act, and one was subject to a Compulsion Order with Restriction Order.
- Twenty nine (64%) detained patients had been receiving compulsory treatment with medication for more than two months. Thus a T2 or T3 form was needed to authorise treatment.
- Overall, the rate of completion of T2 and T3 forms was high, which is good practice. Twenty seven (93%) of the individuals for whom a T2 or T3 form was due had a form in place covering their medication.
- However, two individuals who required a T3 form to authorise their treatment did not have a form in place, and were thus receiving medication outwith the authority of the 2003 Act. Both situations were remedied shortly after our visits but in both cases the request for a designated medical practitioner visit (second opinion doctor) had been made too late. We recommend that the request is made two weeks prior to the authorisation being needed.

Treatment under the Adults with Incapacity Act

Where a patient no longer has the capacity to make decisions about their healthcare, a section 47 certificate should be completed by a doctor. This states that the person lacks capacity to consent to medical treatment, gives the reasons for this, and may be accompanied by a treatment plan setting out the treatments being authorised. Where there is a proxy with the power to consent to medical treatment, they should be consulted where practicable.

What we expect to find

When a patient is receiving medical treatment, their capacity to consent to this should be assessed. If they are unable to consent, a properly completed section 47 certificate, with a treatment plan, if required, should be in place.

What we found

We noted some particular examples of clear assessments of an individual's capacity to consent to treatment, and need for authorisation under Section 47 (or not). This is good practice.

Our comments:

> *"Is capable of making a decision in relation to treatment of pain and for fracture/injury, but not capable for alcohol-related treatments and vitamin replacement."*
>
> *"This man was seen at another hospital, S47 certificate completed then, and on coming to this ward was reviewed again. A new S47 certificate and treatment plan were completed following the most recent assessment."*

Twenty one (14%) patients were felt to lack capacity to consent to treatment. Of these, 18 (86%) had a section 47 certificate in place. In each case where one was not in place, we raised this with a senior nurse and asked that they arrange a medical review to resolve this.

Nine people with a section 47 certificate were receiving treatment for one or more condition covered by an entry for "fundamental healthcare procedures" on their section 47 certificate/treatment plan. We were pleased to find that these treatments were properly authorised for individuals in accordance with the code of practice.

There were no general entries on section 47 certificates/treatment plans for any of these people.

There was a high completion rate of section 47 certificates and the majority of these were well completed in accordance with the Code of Practice.

Locked wards

Of the 24 wards visited, 15 (62%) had a locked door at the time of the visit; nine wards (38%) were unlocked. All four wards that were designated mixed functional and dementia assessment wards were locked. Four wards that were locked had no locked door policy. This is not good practice.

- We recognise that, due to clinical need, it may be necessary for ward doors to be locked at times.
- We consider that it is good practice to regularly review whether the ward door requires to be locked for clinical reasons and to seek to maximise ease of access to or from the ward.
- If a ward door is locked, permanently or periodically, there should be a written locked door policy for the ward. This should be available for patients and relatives to see.
- If a ward door is locked, there should be clear information displayed for visitors and patients about the reasons for this, and about how to ask for the door to be opened if they wish to leave.

- It should be ensured that there is ease of exit for visitors to the ward and particularly for patients who are informal and safely able to go out of the ward on their own.

Some good practice examples:

Our comments:

> *"In Lindean Unit, Borders General Hospital, the door was locked but informal patients were given the code for the door, so that they were able to leave the ward."*

> *"Staff on three wards referred to the door status being regularly reviewed, to decide whether the door required to be locked or not."*

Recommendation

Every unit that has, or may have a locked door, should have a policy in place that ensures the safety of, and respects the rights of, the individual patient.

Unauthorised deprivation of liberty

Whenever we visit we look out for situations where patients are effectively detained without legal authority – unauthorised deprivation of liberty -, as it denies them their safeguards under the 2003 Act.

Of the 86 patients who were not detained, 59 were able to give information about their freedom to come and go from the ward. Forty nine (83%) felt they were unrestricted and 10 (17%) felt restricted. The majority of those who felt restricted had either agreed to be accompanied by staff when off the ward, or needed help due to physical problems.

Patient's comment:

> *"I have to ask the staff - but they let me leave and take me where I want to go. They are very helpful and patient with me."*

Two informal patients indicated unhappiness with restrictions, but neither was able to give a clear answer as to whether they had tried to leave and been prevented from doing so.

No informal patients said they had been told they would be detained if they tried to leave the ward. We checked case notes for the four days prior to our visit for any record of patients trying to leave. Only one incident was found where a patient had tried to leave: she had been assessed regarding detention at the time by a doctor and was due to be reassessed by her consultant on the day of our visit.

We were pleased with our findings: most informal patients were either free to go out or were in agreement with clinical advice restricting this. No-one reported being threatened with detention, and the only person who was actively trying to leave was being regularly assessed for possible detention. This is all good practice.

Access to advocacy

Independent advocacy can be very helpful for individuals. An advocate can help someone to solve problems, ask questions about their care and treatment, and take forward any concerns or complaints. Access to advocacy is an important right and applies to both detained and informal patients.

Staff on all 24 wards said that advocacy was available. Advocacy was available on referral on 14 wards. Advocates regularly visited the other 10 wards, which is good practice.

Eighty seven patients were able to give information about advocacy. Forty six (53%) said they had access to advocacy, but 41 (47%) were either unaware of, or did not have access to, advocacy. Detained patients were more likely to be aware of advocacy: 59% compared to 50%.

While it is good that advocacy is meant to be available on all wards, it is concerning that almost half of patients were unaware of their right to advocacy.

Recommendation

Services should improve information provision for patients to ensure they are informed and kept aware of their right to advocacy.

Being in the ward

Visiting and keeping in touch

Visits, and being able to keep in touch by phone, are very important to patients and to their carers, family and friends. Being in hospital can be a difficult and distressing time, and people can feel isolated from their home life and the community. Contact with family and friends are often the highlight of a patient's day.

What we expect to find

We expect that suitable, comfortable facilities are available for patients to spend time with visitors in private. There should also be facilities for individuals to make private phone calls.

What we found

Of the 96 patients who were able to give us information on visiting, 78 (81%) said there was somewhere private for them to meet visitors. A few said they did not receive any visitors, and 11 (11%) said there were no private visiting facilities.

Our comment:

> *"Visits generally take place at her bedside which is part of a five bed dormitory. Space for private meetings on the ward is very limited. Only rooms available are the dining room or TV lounge."*

We asked nursing staff where visits took place. In most wards, visits took place in public areas of the ward and/or individuals' bedrooms. Only five wards had a separate visitors' sitting room. Twelve wards benefited from an on-site cafe where patients could go with their visitors, and 16 wards made tea and coffee available to visitors. A few wards had facilities for patients to make hot drinks for visitors. We thought this was a good idea.

While it is good that most patients felt they had somewhere private to meet visitors, only five wards had a separate private visiting room.

Of the 91 patients who were able to give information about phone calls, 68 (75%) said they were able to make calls in private. Five (5%) said they were not, the rest said they did not know as they had not tried to make a call. Patients told us that they could make phone calls in private on pay phones, portable phones that they could take to private areas, or on their own mobile phones.

It is good to hear that arrangements are in place for most people to be able to make phone calls in privacy, however all patients should be able to make phone calls in private unless there is legal authority for calls to be restricted or monitored.

Recommendation

The right to privacy, dignity and family life should be respected. All patients should be able to have private space, be able to make calls in private, and have a private area to see their family and friends when visited, unless there is significant risk to either themselves or others.

Feeling safe and having personal possessions

What we expect to find

We would expect all patients to feel safe while in hospital. Patients should be able to have personal possessions while in hospital, and a means of keeping their belongings safe.

What we found

Of the 96 patients who were able to provide information about how safe they felt, only one patient did not feel safe. On further enquiry she explained that she felt unsettled by the noise on the ward, but did not feel physically unsafe. We were pleased that virtually all patients felt safe.

Having personal possessions can make being in hospital more positive. Not being able to keep possessions safe in hospital can be upsetting for patients.

Only a third of wards had arrangements for individuals to be able keep possessions in their own locked drawer or cabinet, or to lock the door of their single room.

A quarter of wards did not have arrangements for anyone to do so.

Patients should be able to keep personal belongings in their possession, and know that they are safe.

Recommendation

Wards should have appropriate arrangements in place to allow patients to safely bring some personal possessions into the ward.

The ward environment

What we expect to find

Patients should be cared for in wards that are clean, comfortable and well maintained. The ward environment should be therapeutic, safe and conducive to people maintaining their privacy and dignity. There should be easy access to gardens that are attractive, well maintained and safe.

What we found

All wards were felt to be clean, and all but three well maintained. One of the wards considered poorly maintained caused concern:

Our comments:

> *"The ward is a converted medical ward and absolutely not fit for purpose. Heroic attempts by staff to make it as comfortable as possible though."*

> *"In a very poor state despite some recent repairs - damp at the windows, mould in shower. Toilets, although clean and odour-free, were in a poor state. Hoists and other equipment in a part of the corridor as there was no where to store them. Parts of the flooring in a state of disrepair…….there was very little in the way of signage."*

We saw some good examples of appropriate, therapeutic ward environments.

Our comments:

> *"Excellent environment. Well thought out in terms of observation and communal spaces. Bedrooms all en-suite (two for wheelchair users if required). Accessible garden. All of high standard. Ward has pleasant ambiance, warm, clean and well maintained. Fireplace in main sitting area - nice focal point."*

> *"Ward is quite spacious (apart from very small duty room for staff). All patients have en-suite and individual bedrooms, with hanging space on wall so that room can be personalised with photos etc. Ward is clean, bright and welcoming."*

> *"Ward is well maintained and had a nice calm feel on the day of the visit. Spacious, with a range of rooms to use for different activities and quiet time."*

Staff were asked if there was anything they would like to change about the ward environment. There were recurrent themes, including:

- Shared bedrooms - need for more single rooms. Individuals are afforded more privacy and dignity where single, en-suite rooms are available.
- Issue of shared bathrooms.
- Lack of relatives rooms, or other private areas for people to go or take visitors.

There is considerable variation in quality of the environment between different wards. Some wards are well designed, purpose-built units with good facilities and single en-suite rooms. We saw services working well to make available facilities as comfortable, homely and therapeutic as possible. However, there were considerable environmental issues in a few wards.

It is particularly concerning that individuals in some wards require to share bedrooms, and that they may experience privacy and dignity issues due to this.

Recommendation

Functional assessment wards for older people should be enriching therapeutic environments, conducive to an individual's recovery. Wards should be well-maintained. People should feel comfortable and able to maintain privacy and dignity while in hospital.

Individuals should be able to spend time off the ward to get fresh air, peace and exercise. Having access to ward gardens or other outside space can enable them to do this. This can be particularly important for people who are detained or cannot safely go out of the ward unescorted.

What we found

Two thirds of wards had accessible garden areas, the majority of which we considered to be safe, attractive and well maintained. This is good practice.

Our comments:

> *"The garden door is open. The garden area is good and accessible from four points in ward. It has trees, grass, beds and a greenhouse."*

> *"Good large garden, well kept, with raised beds and space for walking outside."*

We noted particular issues on two wards with access to the garden, due to the ward not being on the ground floor:

Our comment:

> *"Garden is not accessible. Ward located on second floor, and can be difficult to have staff to assist vulnerable/ patients with mobility difficulties to garden area."*

We found two ward gardens we considered unsafe:

Our comment:

> *"The garden/courtyard was littered with cigarette ends. It is dirty, unsafe in physical layout (stone chips), and not safe for older people to access. We were told that a patient had fallen whilst going down the ramp."*

Three wards had no access to a garden at all. This is not acceptable.

Almost a third of wards did not have easily accessible, safe garden areas. We appreciate that there are plans underway to re-provide some of these wards in new facilities, which will

benefit patients and staff. In the meantime, patients are being disadvantaged by being in wards without easy garden access.

Recommendation

Hospitals should ensure that there is an easily accessible, safe and secure outside area.

Patient mix on wards

Four wards we visited were formally looking after both functional patients and patients with dementia. They generally reported that they had a larger proportion of dementia patients than functional patients. In addition, 13 (65%) of the other 20 wards reported that they regularly had patients with dementia on them.

The majority of staff interviewed felt that having patients with dementia on the wards presented some issues. Most commonly, staff reported that patients with dementia required more nursing time, had more complex needs, and that the functional patients often found it difficult to understand or tolerate patients with dementia.

Wandering was a common problem described by staff, and they stated that patients often complain about this on the wards. Nursing staff are also aware that patients recognise that more time is spent with dementia patients, at the expense of time with other patients.

Patients also commented on their experience of being on the same ward as patients with severe dementia. Issues that can arise include dementia patients going into others' rooms or going through others' belongings. The following are comments from patients on a mixed ward on this matter:

Comment:

> *"Having a mixed ward means that nurses have to spend a lot of time on personal care tasks for the dementia patients, and often apologise about not having enough time to talk with him. He also said that if he leaves his door open these patients will often come in and take things or move things around in his room."*

One female patient said that:

> *"The functional/dementia mix doesn't work. Staff time is spent physically caring for and monitoring dementia patients, with very little time left for functional patients."*

It is important that services carefully consider the mix of patients to ensure the care needs of all patients in the ward can be met and the experience of inpatient care is as positive as possible.

Discharge

We recorded that there were problems with discharge arrangements for 24 individuals (19%), with 14 categorised as “delayed discharge” (i.e. 11% of all individuals).

Reasons stated for delays to discharge included:

- Awaiting a care package
- Awaiting decoration/adjustments to housing
- Application for guardianship
- Delay in obtaining the desired resource
- Difficulty finding placement
- Difficulty finding funding for placement.

Appendix

Table 1: ACUTE FUNCTIONAL ASSESSMENT WARDS FOR OLDER ADULTS IN SCOTLAND (ALL VISITED)

Heath Board	Hospital	Ward	Functional Assessment (F) alone or Mixed F + Dementia (M)	Number of Beds
Ayrshire & Arran	Ailsa	Croy	F	14
Lanarkshire	Airbles Road	Colville	F	9
Ayrshire & Arran	Ayrshire Central	Pavillion 2	F	15
Borders	Borders General	Lindean	F	7
Lanarkshire	Coathill	Glennevis	F	10
Forth Valley	Forth Valley Royal	Ward 5	F	18
Greater Glasgow & Clyde	Gartnavel Royal	Timbury	F	25
Greater Glasgow & Clyde	Inverclyde Royal	Ward 4B	F	10
Tayside	Kingsway Care Centre	Ward 4	F	14
Greater Glasgow & Clyde	Leverndale	Banff	F	20
Lothian	Midlothian Community	Rossbank	M	24
Dumfries & Galloway	Midpark	Glencairn	F	15
Tayside	Murray Royal	Leven	F	14
Highland	New Craigs	Morar	F	12
Fife	Queen Margaret	Ward 1	M	24
Greater Glasgow & Clyde	Royal Alexandra	Ward 39	F	20
Grampian	Royal Cornhill	Muick	F	24
Grampian	Royal Cornhill	Skene	F	20
Lothian	Royal Edinburgh	Eden*	F	30
Lothian	St John's	Ward 3	M	12
Greater Glasgow & Clyde	Stobhill	Isla	F	24
Tayside	Stracathro	Rowan	F	15
Fife	Stratheden	Muirview	M	24
Greater Glasgow & Clyde	Vale of Leven	Katrine	F	6
			Total	**406**

All wards are **mixed sex** wards but for:* **Eden ward is divided into two units – one with 18 beds for women, and a 12 bedded "male" unit (which actually had 8 beds occupied by men and a 4 bedded dorm occupied by women on the day of the visit).**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Mental Welfare Commission (Oct 15)