Mental Welfare Commission for Scotland

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

Date of visit: 8 December 2020

Where we visited

Pentland Ward is an eight-bedded ward for men with a diagnosis of dementia who have complex care needs. Whilst predominantly providing care for men over the age of 65, younger patients with early onset dementia may also receive care on the ward.

We last visited this service on 23 October 2018 and made recommendations about care planning and documentation relating to aspects of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

When we visited in 2018, Pentland Ward was situated on the ground floor of the Jardine Clinic, in the grounds of the Royal Edinburgh Hospital (REH). It was the only ward open in the building at that time, although we were advised of plans to refurbish the building.

In December 2019 we were advised that Pentland Ward had been decanted temporarily to another ward (formerly Comiston Ward) to facilitate the required renovation work at the Jardine Clinic. Patient numbers were reduced (from 14 to 8) to accommodate this move.

Comiston Ward previously provided inpatient rehabilitation for older adults. The ward was closed in recent years after the inpatient service ceased. Comiston Ward is one of the older wards in the hospital and, prior to its closure, concerns had been raised on previous Commission visits about the suitability of the environment for inpatient care.

The temporary relocation of Pentland Ward was planned for a period of three months. However, due to Covid-19, building works at the Jardine clinic were suspended in March 2020. Renovations have yet to recommence. At the time of this visit, Pentland Ward has remained housed in Comiston Ward for 12 months. We were told there were no imminent plans for relocation to the Jardine Clinic or proposed timescales for this to happen.

On the day of this visit we wanted to follow up on previous recommendations. We also wanted to see the environment where care was being delivered, as senior staff and managers had raised concerns with us about the ward as delays progressed.

Who we met with

The visit was carried out in a Covid-19 secure manner, with use of PPE and social distancing throughout. We observed patients interacting with staff and participating in activities on the ward and reviewed individual patient records. We also looked at the environment and met with senior staff.

We reviewed the care and treatment of four patients and spoke with one relative after the visit. We met with the service manager, senior charge nurse (SCN) and other nursing staff.

Commission visitors

Juliet Brock, Medical Officer

Alyson Patterson, Nursing Officer

What people told us and what we found:

Care, treatment, support and participation

When we arrived on the ward in the morning the atmosphere was lively and welcoming. A number of patients were moving around the communal areas, and we observed staff supporting them one a one-to-one basis; we noted that interactions between staff and patients were warm and engaging. It was evident that staff knew individual patients well and were tailoring their approach according to the person's communication style and individual needs. For example, we observed one patient mobilising around the ward with a member of staff, who was offering physical support whilst singing along with the person's chosen songs.

We noted that each patient we saw was well-presented, well-groomed and dressed in clean clothing. The family member we spoke with also commented on this aspect of care and told us that their relative was "always beautifully presented" when they visited (they noted that their loved one was always clean-shaven and had been given a recent haircut). The staff told us that the men's personal care was a priority, and attended to daily. We were advised that care plans had been carefully developed to provide individualised support for any patients who were unwilling or distressed; the ethos of the team being against the use of any restraint in providing personal care.

The approach of nursing staff was reflected on by the relative we spoke with, who was very positive about the nursing team. The relative spoke of how well the staff knew the men in their care and were able to provide a calm atmosphere on the ward.

There had been a change in senior nursing staff during the 12 months prior to our visit. The new leadership team had overseen both the transition to Comiston Ward and managed the subsequent impact of Covid-19. Despite these challenges, we were told the team had been able to undertake a number of new initiatives during this time, including improving care planning, working intensively to support patients who exhibited stress and distressed behaviours, and enhancing staff education and knowledge. We saw evidence of some of this work in the notes we reviewed.

We were told the team had also worked proactively during the previous year to support the discharge of patients to the community (either to care homes or to patient's own homes with support). Twelve patients had been successfully discharged over the year. The absence of any 'failed' discharges was attributed to careful planning, with joint assessments being carried out with care homes, to ensure the home and staff were able to meet the individual's needs. The support of the Lothian Rapid Response Team (an intensive outreach team for older adults in the community, who are able to offer daily visits when required), was also key in supporting some patients during their transition from hospital.

Impact of Covid-19

Whilst the ward had remained free of Covid-19 during 2020, the pandemic had presented challenges for patients, their families and for staff. Visiting had been restricted at times, as required by national health protection guidance implemented across NHS Lothian (exceptions being made for individuals receiving palliative care). The staff had supported patients and

families to maintain contact throughout by use of phone calls, 'virtual visits' using tablets and arranging 'window visits' so that patients could safely see their loved ones in person. The relative we spoke with said it had been a very difficult time, but that the staff had made considerable efforts to support families, including sharing photos and videos.

On the day we visited, the first Covid-19 vaccinations were being given in the UK. Managers advised us that a vaccine clinic had been set up on the hospital site and that priority groups were to start receiving vaccinations that afternoon.

Patient records

On our previous visit in 2018, patient notes were held in paper files. With this visit, a transition to the online NHS Lothian TRAK system has taken place and patient records were being updated electronically, although some documents are still on paper files. Prescribing had also recently moved to electronic prescribing and dispensing on HEPMA.

The files we looked at had detailed 'Getting to Know' me documents, completed by the person's family. We found the paper files were well organised and documentation could be easily found

The nursing care plans we viewed were detailed, person-centred and of a high standard. We saw examples of defined individualised care plans supporting both mental and physical health care. In particular, the care plans we viewed for managing personal care and stress and distressed behaviours identified the person's needs and explored the range of interventions that worked well for them. We found that the care plans included using a person's 'playlist for life' during bathing and naming individual songs to which they responded particularly well. Activity care plans also carefully considered meaningful activities for the individual, including details of their past work and interests to inform the plan.

We saw evidence that new care plans were added as further care needs were identified. Monthly care plan reviews were also in evidence. The reviews themselves offered meaningful detail, sometimes identifying interventions that had been trialled, exploring what had and hadn't worked. We also saw reference to multidisciplinary team (MDT) discussions agreeing care going forward (and example of this was in care plans for pain management). The records also contained MDT meetings and action plans from these.

In the daily record for the patients there was a strong focus on detailed personal care. Whilst important, we felt there could sometimes have been more focus day to day on recording an individual's mental health and participation in activities.

We found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in the files we viewed, and ceiling of care forms completed. Covid-19 anticipatory care plans were also in place. We saw confirmation of the involvement of relatives in decision making in relation to these documents.

The Commission has produced Good Practice Guidance on person-centred care plans which can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Multidisciplinary Team
We were told that the ward is nurse-led, with input from a consultant Psychiatrist once a week and support from a full-time junior doctor. There was no occupational therapy (OT) input to the ward at the time of our visit. There is a full time activity co-ordinator who supports nursing staff and provides one-to-one sessions or small group activities. We heard that the ward has psychology input for one day a week. Psychology support for older people had recently been introduced across the dementia assessment services and HBCCC wards.

We received feedback from a relative that they had not had any contact with medical staff throughout their relative's stay on the ward and had not been invited to review meetings (including via virtual means). We were told by managers that locum medical cover had been in place for a period, but that a permanent consultant now provided input to the ward. It is important that communication with relatives about each patient's treatment and longer term management plan takes place, and that invites to MDT meetings or other appropriate forums are offered on a routine basis.

Use of mental health and incapacity legislation
For those patients subject to the Mental Health (Care and treatment) (Scotland) Act 2003 ('the Mental Health Act'), we found copies of appropriate documentation on file. Where a patient was subject to the MHA, we found the appropriate (T2 or T3) certificate in place to authorise medical treatment.

Section 47 certificates were in place for patients who lacked capacity to consent to their care and treatment, in accordance with the AWI Act.

Rights and restrictions
A number of patients were receiving medication covertly. Appropriate covert medication pathway documentation had been completed in these cases and we saw evidence of planned review dates.

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 were told that all nursing staff supported the activity co-ordinator in facilitating both individual and small group activities for men on the ward.

There is no activity timetable for the ward and we were advised that large group activities do not work for the patient group on Pentland Ward (Covid restrictions would also have limited

such groups even if they had been appropriate). Instead, each patient had an individualised activity care plan. We saw evidence of this in the records we reviewed. We also found details in the notes to individualised activities taking place; an example included a 40 minute one-to-one music therapy session, and use of another patient's playlist for life. Whilst we saw evidence of some activities being recorded in patient notes, we suggest that this could be further improved.

Music therapy appeared to be a strong focus on the ward, with weekly sessions from a visiting music therapist. The music therapist contributed to care plans and at the time of our visit was making individual DVDs of photos and video clips for each patient's family for Christmas. The relative we spoke was complimentary about.

It was acknowledged by the nursing team that patients' ability to go on outings and to engage in activities in the wider community had been significantly curtailed during the pandemic. At times in the summer, when visiting restrictions had eased, outdoor visits with nominated family members had been permitted.

The physical environment

The ward is housed in one of the older parts of REH. In comparison with the older adult wards in the new Royal Edinburgh Building, it does not provide purpose-built single rooms or en-suite facilities.

Although the ward has been modernised in recent years, it appears dated, is not designed to be dementia friendly and was not at all suited for the group of men who require specialist HBCCC dementia care in Pentland Ward.

The patient bedrooms we viewed were small and cramped. The communal shower room was not in use and not designed to enable staff to support individuals with their personal care. Patients were therefore unable to shower and all were receiving baths. Some of the toilet facilities on the ward were cramped, and institutional looking, with old sanitary fittings, as noted when we last visited the ward space in 2018.

While the central communal 'hub' on the ward provides a space for people to sit and engage, the large communal lounge is uninviting. There is limited flexible spaces on the ward for patients to engage in activities or enjoy quiet time. This was a particular issue during the pandemic, with the requirement for social distancing.

The current garden area is a small enclosed concrete courtyard. As highlighted in our last visit, the uneven surface poses a potential trip hazard. The staff have made attempts to make the space more inviting by providing bench seating and some planters. This limited space was used for outdoor family visits. Whilst adequate for this purpose, it was not an inviting space to spend time in.

Throughout the Commission's contact during the pandemic in 2020, both managers and ward staff highlighted that the environment was not fit for purpose. We agree that the current ward is not a suitable environment for the patient group currently being cared for there. It is a

concern that the temporary re-location of the ward has extended, with no imminent plans for the patients to be returned to the Jardine Clinic.

Recommendation 1:
Hospital managers should prioritise refurbishment of the Jardine Clinic. The Commission requests confirmation of the timescale in which this will happen.

Summary of recommendations

1. Hospital managers should prioritise refurbishment of the Jardine Clinic. The Commission requests confirmation of the timescale in which this will happen.

Good practice

We commend the progress the staff team have made with individual care planning since the Commission's last visit. We would encourage this learning and good practice to be shared with other older people's services in Lothian.

Service response to recommendations

The Commission requires a response to this recommendation within three months of receiving this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland

CLAIRE LAMZA
Interim Executive Director (Practitioners)

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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