mentalwelfare
commission for scotland

Where do I go from here?

Report from our visits to people admitted to mental health assessment wards for older people in Scotland

June 2010

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WHO WE ARE AND WHAT WE DO

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should

- Be treated with dignity and respect.
- Have the right to treatment that is allowed by law and fully meets professional standards.
- Have the right to live free from abuse, neglect or discrimination.
- Get the care and treatment that best suits his or her needs.
- Be enabled to lead as fulfilling a life as possible

OUR WORK

- We find out whether individual treatment is in line with the law and practices that we know work well.
- Challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

OUR VISITS

One of the ways in which the Commission monitors individual care and treatment is through our visits programme.

We visit people in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered. As part of our visits programme we visit people in hospital. This report reflects our findings from a special programme of visits to mental health admission wards for older people, a national themed visit. The aim of national themed visits is to enable us

to assess and compare care and treatment for particular groups of people across Scotland Our aim is to help services learn from good practice and to respond to any issues that are identified. This report provides an overview of our findings from a series of visits that took place across Scotland between 4 June 2009 and 27 August 2009.

WHY WE VISITED

The Commission regularly visits mental health admission wards for older people. We became aware that some common themes were emerging from these visits. These common themes related to often poor physical environments, a lack of provision of therapeutic activities and other issues such as consent to treatment and awareness of and respect for individual legal and human rights. All of these factors have an impact on the individual's capacity to recover or adjust during their time in hospital.

These findings were similar to those we highlighted in our report in 2007, Older and Wiser. That report followed a series of 17 unannounced visits to NHS continuing care wards for older people. That report focused on NHS continuing care units but the findings and recommendations were relevant to admission units and we were interested to see how admission units compared with the findings in Older and Wiser. We thought a good way to do this was to visit mental health admission units for older people across Scotland as part of our 2009-2010 visiting programme.

HOW WE CARRIED OUT THE VISITS

In June, July and August 2009, we visited the majority of mental health admission wards for older people across Scotland; we met with a total of 197 people receiving care in 62 wards across 43 sites. Appendix 1 provides a list of wards we visited.

The majority of wards we visited admitted people for assessment and treatment of either functional mental illness or dementia but some admitted both groups. For the purposes of this report, the term "functional mental illness" applies to older people with mental health problems such as depression and bi-polar disorder but excludes those with dementia**.**

Our visits were announced in advance so that people who had particular concerns could arrange to meet with us. We also asked people we met on the day if they would be willing to share their experiences with us by answering some prepared questions.

We went to each ward and asked staff a series of questions about the people admitted to the ward on the day of the visit and about how their care and

treatment was provided. Where possible we met with relatives and carers who happened to be in the ward at the time, or had requested a meeting with us. We took time to look around the wards and paid particular attention to the physical environment and people's involvement in activities. We completed questionnaires with people about their environment and the therapeutic activities provided for them.

We also examined at least two sets of care notes in each ward to look at the care being delivered. This was particularly important to ensure we got a broad view of the care being delivered as not everyone we visited was well enough to express their views directly.

By looking at different sources of information we were able to get a broad picture of care in the wards we visited. Our observations and what people told us form the basis of the findings in this report.

The main areas we cover in this report are:

1. Respect for the rights of the individual

2. Provision of therapeutic activity and respect for individuality

3. The physical environment

KEY MESSAGES

We have developed the following seven key messages so that hospital managers, clinical and professional leaders and others can use them to consider the care they provide and make improvements where necessary.

They should be considered together with the recommendations for action needed highlighted in each section.

1. People's freedom should be respected as far as possible when they are in hospital and 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 mental disorder, not just to those subject to compulsory treatment under the Mental Health (Care and treatment) (Scotland) Act 2003.

4. Staff must be aware of and understand the provisions of Parts 2 and 6 of the Adults with Incapacity (Scotland) Act 2000; in particular the need to consult with welfare guardians and attorneys.

5. Food and drink must be available, easily accessible and of good nutritional quality. People should receive the level of assistance they need to make the most of the social and therapeutic opportunities that mealtimes provide.

6. Assessment wards must provide opportunities for stimulation through physical and therapeutic activities in 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.

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

SECTION ONE

RESPECT FOR THE RIGHTS OF THE INDIVIDUAL

LOCKING THE FRONT DOOR

KEY MESSAGE

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

Why we looked to see if doors were locked

Locking doors in hospitals to stop people from leaving is a form of restraint. Any restriction on the freedom of movement of a person by others should only be considered when an individual is considered to be at risk.
We wanted to know that if an individual's personal freedom was being limited that this was being done in a legal, compassionate and ethical manner.

What we would expect to find

There may be occasions when for reasons of personal safety and security that it is necessary for the main exit door to be locked.

When we come across a locked exit door we expect to be given a reasonable explanation for it. We also expect that a local policy, regularly reviewed, is in place and that any restrictions are being carried out in an ethical manner that respects the rights of all the people on that ward.

What we found

Of the sixty-two wards that we visited, the majority had a locked front door.

Some hospitals had taken a decision, for security reasons, to have the main entrance door locked, usually to control who entered the ward but people inside the ward could still exit freely.

Community and cottage hospitals that we visited were more likely than other hospital wards to have a locked door.

Wards for people with dementia were twice as likely to be locked as those for people with functional illness alone.

Ward type (functional, dementia or both) by whether main door usually locked

			Door Locked		
			Yes	No	Total
Functional, dementia or both	Functional	number	7	9	16
		As percentage	*44*	*56*	*100*
	Dementia	number	27	6	33
		As percentage	*82*	*18*	*100*
	Both F and D	number	11	2	13
		As percentage	*85*	*15*	*100*
All wards		number	45	17	62
		As percentage	*73*	*27*	*100*

On the wards where the main exit door was locked, we asked the nurse in charge to tell us about the door locking policy. We wanted to hear about the reasons for the door being locked, who had been consulted prior to this decision being taken and how often the decision was reviewed.

In only half of these wards did we receive a satisfactory response.

Some wards told us that there was a door locking policy in place but when we explored this further we were told that the policy simply was a practice that the door was permanently locked. We did not accept this as a satisfactory response.

We visited a functional assessment ward that we had visited many times previously. This ward always had the front door open except on rare occasions when the local policy had been put in place. At this visit the front door was locked. We asked why this was and were told the new charge nurse had taken the decision to permanently lock the door. This had not been discussed with anyone else and had quickly become an accepted practice. We asked that the managers urgently review this practice.

We visited a ward that admitted some older people but was an adult acute psychiatric admission ward in a large general hospital. The design of the ward was not sympathetic to the needs of some of the older people admitted there. The main exit door opened automatically as you approached it and staff told us this was problematic as often people were not looking to leave but did so when the door opened automatically for them as they approached.

Good practice example

At St John's hospital the mixed functional and dementia assessment ward has introduced a swipe card system for the main exit door. Following a risk assessment, anyone who can use these cards is given one so they can freely exit the ward.

Action needed

- **All assessment wards for older people must, if the door is either permanently or temporarily locked, have a policy in place for locking the door. This policy should include a statement as to the reason for this and a clear monitoring and review process. It must also address the rights of people who are not detained under mental health legislation.**

- **People who want to leave the ward and who are able to do so should not have unnecessary barriers put in their way.**

- **The use of technology can help minimise the limits on a person's personal freedom and its use should be considered.**

CONSENT TO TREATMENT

KEY MESSAGE

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.

Why we are interested in consent to treatment.

People should receive medical treatment that is in line with the law. From the visits we carry out to hospitals, care homes and in people's own homes we know that often this is not happening. If people are not able to consent to their own medical treatment then hospitals should use the law properly to safeguard them. For people unable to give valid consent, their treatment must comply with the Adults with Incapacity (Scotland) Act 2000(AWIA) and part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 where indicated.

What we expect to find

Part 5 of the AWIA gives a general authority to treat a person who is incapable of consenting once a certificate of incapacity has been issued. For people who require them, we would expect to find Section 47 AWIA (certificates of incapacity) in place and an attached treatment plan for people requiring multiple or complex healthcare interventions.

What we found.

We found incomplete compliance with Part 5 of the Act.

We reviewed the individual case records of people that we thought required a Section 47 certificate. We based our judgement on who needed a certificate by talking to the person, the nursing staff and reviewing the care file.

Of the people we identified as needing a Section 47 certificate, we found about a third of the people seen in dementia assessment wards and functional assessment wards were without appropriate Section 47 certificates. In combined assessment wards the proportion without Section 47s where needed was much higher, at nearly two-thirds.

Action needed

- **All assessment wards for older people must have procedures in place to assess and review people's capacity to consent to treatment and to ensure completion of appropriate legal certificates when required.**
- **Assessment of capacity to consent to medical treatment should be carried out at the point of admission. Capacity to consent to medical treatment must be assessed as a matter of course and be subject to regular review**

- **NHS Boards should regularly audit compliance with Part 5 of the Act**

- **All wards should have access to Part 5 AWIA Code of practice and General Medical Council "Consent Guidance: Patients and doctors making decisions together".**

- **All wards should make available the information leaflet "Caring and consent, information for carers".**

RIGHT OF ACCESS TO ADVOCACY

KEY MESSAGE

The right of access to advocacy extends to everyone with a mental disorder, not just to those subject to compulsory treatment under mental health law.

Why we are interested in advocacy

The Mental Health (Care and Treatment) (Scotland) Act 2003 introduced the right of access to independent advocacy services for all people with a mental disorder. We were interested to find out how easy it was for people to access independent advocacy and if advocacy was being used regularly in wards for older people.

What we would expect to find

All relevant staff should know about the right to independent advocacy and its role, the legal requirements relating to independent advocacy under the act.

We expect to find evidence that people have been informed of their right to an independent advocate and that people with impaired capacity are given help to engage with an advocate. This should happen for all people, not just people who are detained.

What we found

We found that just over half of people seen in functional assessment wards had been told about advocacy and this had been entered into their care file. This compares with just under half of those seen in dementia assessment wards and combined wards. We based our decision upon whether someone had been informed about advocacy by asking them and/or looking at care files to see if this had been recorded.

Circles Advocacy is on site. Response time is very good and there is a specialist older people advocacy worker, really helpful. Royal Edinburgh Hospital.

We found that informal patients are much less likely to have been informed about advocacy than patients who are in hospital on a compulsory basis. We heard from staff that in some areas local advocacy services were only able to work with people who needed their help with mental health Act matters.

Most wards we visited had promotional materials for the local advocacy service displayed, but quite often individual patients and their relatives were unsure

about what advocacy was. We feel it is important to supplement these general advertisements with specific information for individuals.

We also heard from staff who said that they would only refer someone to the advocacy service if there were no involved relatives. This is not consistent with the right of individual access and suggests a misunderstanding of the role of independent advocacy in individual care and treatment.

Action needed

- **All older people in assessment wards must be individually informed of their right to independent advocacy. Where people lack capacity, staff should do their best to help them exercise that right.**

- **Advocacy services should be available to everyone with a mental disorder, not just those detained in hospital under the mental health Act.**

STAFF UNDERSTANDING OF PART 2 AND PART 6 OF THE ADULTS WITH INCAPACITY SCOTLAND ACT 2000

KEY MESSAGE

Staff must be aware of and understand the provisions of Parts 2 and 6 of the AWI Act, in particular the need to consult with welfare guardians and attorneys.

What we would expect to find

We expect hospital staff to follow the principles of the Adults with Incapacity (Scotland) Act 2000 and that they should know about the parts of the Act that people they care for may be subject to.

What we found

In all wards we visited we asked about the number of people who were subject to guardianship and if staff knew who the guardian was and their powers.

Whilst most staff were able to tell us who was subject to Guardianship or where an application had been made, their understanding of what this meant was variable. Staff were often unclear about who the Guardian was, the difference between a Guardian and someone with Power of Attorney and whether they had welfare and/or financial powers.

We think that in an assessment unit where plans will be made about a persons future care needs, it is vital staff know and understand the AWI Act and its implications.

Action needed

- **Anyone subject to the provisions of the AWI Act should have this information clearly recorded on their profile sheet.**

- **Staff should be aware of and receive training in the provisions of the Act that relate to the people they care for.**

FOOD AND DRINK

KEY MESSAGE

Food and drink must be available, easily accessible and of good nutritional quality. People should receive the level of assistance they need to make the most of the social and therapeutic opportunities that mealtimes provide.

Why we are interested in food and drink

As well as looking at the environment where meals were served we also asked staff about access to food and fluid and the assistance available to people. (We say more about the environment in dining areas later in this report).

We asked these questions because many concerns have been brought to our attention, and to the attention of the Scottish Public Services Ombudsman, about older people not having adequate food, fluid and nutrition whilst in hospital. The Scottish Government launched in 2008 their Food, Fluid and Nutrition programme and NHS Quality Improvement Scotland have in place clinical standards for food, fluid and nutritional care in hospitals.

What we would expect to find

We would expect that people would be able to easily access the food and drink they need and receive the level of assistance they need to ensure a healthy diet whilst in hospital.

What we found

On all wards we visited we observed the lunchtime meal serving.

We found that the overwhelming majority had a protected meal time system in place. This means that there are periods of time on a hospital ward when all non urgent clinical activity is stopped. During these times people are able to eat without being interrupted and staff can offer assistance. Everyone we spoke to told us that they think protected mealtimes are a very good idea and appear to be working well. We did though find differences in how strictly the practice is followed.

One nurse told us that in protected meal times

"Staff time is focused on the patients, we have quite a few people with depression where food intake can be a problem and staff have time to ensure they eat".

We visited some wards where although there was a protected meal time system in place, staff told us that this didn't work and the usual ward routine continued around the meal time. Nursing staff did comment that they found medical staff were most likely not to comply with protected time requirements.

We also asked nursing staff if they felt they had enough time and staff at mealtimes to ensure everyone was able to get the assistance they needed. The majority of nursing staff answered that they thought they had adequate staff on duty at mealtimes and always ensured that a trained member of staff was involved in the mealtime.

One of our visitors who observed a lunch serving commented

"*Meal time very hectic, nurse standing to feed someone in a wheelchair who then had two different members of staff for each course. Everybody had plastic bibs on regardless of whether they needed it".*

Another visitor observed

"One lady was sitting not eating her food, a plate of meat and potatoes; everyone else was on their pudding so it was likely that her food was cold. She appeared agitated but was ignoring her food. I prompted her that her lunch was there. She attempted to eat with the knife but she needed some help to recognise the fork. At this time there were two nursing staff standing at the food trolley that had not up to this point thought to intervene"

In addition to looking at the dining areas, we asked nursing staff about the catering arrangements and in particular facilities for people to make drinks and snacks at any time of the day or night. We think that it is important for people to maintain their everyday skills wherever possible while in hospital.

Under half of the wards visited had facilities to make snacks at any time. In eighteen wards we found that drinking water was not easily accessible to people: they would need to ask staff to fetch a drink for them or wait to be offered it.

In one hospital we found a water fountain but it was in the dining room which was locked for large parts of the day.

It is not acceptable that in 18 of the sites we visited patients did not have easy access to drinking water. This was usually because the main kitchen area was locked and patients and visitors would have to ask staff to open this for them and then help them to get what they wanted.

In one new PFI (private finance initiative) hospital the meals are served with up to three courses already placed on one tray. Staff thought it was confusing for

some people to have all the courses served like this and also that there are a lot of issues with food, but they are “stuck” with the catering contract.

We also asked about access to a dietician and were told overwhelmingly that it was quick and easy to refer and get access to a dietician. Only one ward we visited reported a problem with this and we brought this to the attention of the managers.

Action needed

- **All assessment wards for older people must try to ensure that people enjoy the dining experience and that they are given individual assistance that meets their individual needs.**

- **All older people in assessment wards must have easy access to drinking water. This is particularly important for older people who are prone to dehydration**.

- **Staff need to promote independent living skills. Limiting access to facilities and support for making drinks and snacks interferes with independent, everyday living skills and wards must improve access to these.**

SECTION TWO

PROVISION OF THERAPEUTIC ACTIVITY AND RESPECT FOR INDIVIDUALITY

KEY MESSAGE

Assessment wards must provide opportunities for stimulation through physical and therapeutic activities in 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.

PROVISION OF THERAPEUTIC ACTIVITY AND THE ACTIVITY CULTURE

Activity is essential to an individual's health and wellbeing. It has the potential to restore, maintain and improve physical and mental health. Our individual personality, life history, interests, values and beliefs influence our choice of activity. In short, what we do says a lot about who we are.

If an individual experiences disruption of daily routines, or has access to only a limited range of activities, physical and psychological health will suffer.

Why we are interested in this

Although the ability to perform basic activities is important, the need to enable social engagement and purposeful activity are key to encouraging a sense of self worth and well-being. Staff with the relevant knowledge and skills to provide appropriate activities can enrich the relationships within the ward to keep the activity culture vibrant and alive.

What we would expect to find

We would expect all staff to share responsibility for ensuring there is a culture that promotes and includes activity for individuals in all aspects of their daily life. We would expect individuals to be free to engage in personal and social activities of their choice in a relaxed and friendly environment.

We would expect the range of activities for each individual to reflect their choice, their social, cultural and religious preferences, and to be available at frequent and regular intervals throughout the week.

We would expect there to be sufficient financial and other resources, such as transport, equipment, materials, training and facilities, and effective use of the available environment and local community. We would expect that people are supported to participate in activities of their choice.

We would expect the need for “quiet time” and quiet space to be recognised and respected.

What we found

In wards where there was an activity culture, we saw individuals participating in a variety of leisure and daily interests that reflected their hobbies and interests that matched their level of ability.

Activities we found took many forms such as:

Daily living activities e.g. washing, dressing, managing medicines, eating, laundry, snack/meal preparation, budgeting, taking buses and taxis, going out to the shops and meeting friends for coffee.

Health and wellbeing activities used to address individuals cognitive, sensory and physical needs e.g. singing and playing musical instruments, dance classes, reminiscence groups, crosswords, quizzes, baking, art, crafts, therapets, snoezellen, massage, walking, swimming and gentle keep fit.

Lifestyle management activities including learning how to live with depression, anxiety management, healthy eating, smoking cessation, community education and leisure activities.

Person centred activities to improve the quality of the individual’s life e.g. staff taking the time to sit and chat socially on a one to one or small group basis with individual patients and carers, facilitating patients to visit spouses who may also be in hospital or a care home or have transport difficulties, ward visits by relatives, friends, neighbours, outings to local parks, museums and the cinema, going to watch football, eating takeaways, the provision for “quiet” time and privacy.

Wards with a culture of activity provision supported individuals to do these things throughout the whole day, not just the organised groups in traditional activity programmes. This culture was underpinned by regular meetings between the patients and staff to plan the week’s activities.

Some wards had developed meaningful social and community connections for individuals through the introduction of volunteers, befriending services, local churches, artists and musical groups visiting the ward throughout the day, in the evenings and at weekends.

However our visitors came across many missed opportunities to use activities therapeutically for the benefit of the individual. On meeting one individual and reading the last review in her case file, a visitor commented,

"This lady's mental health has improved but she remains physically frail. There is no mention to even suggest that activities of any sort have been considered, let alone been offered and adapted to meet her capabilities."

Individuals told visitors: "*The only activity on offer is relaxation – every morning. That is it!"*

"I enjoy painting water colours. I spend a lot of time doing that at home. I was told by staff that they don't do water colours on the ward."

"There isn't much going on in the ward. It all depends on who is on duty."

One visitor observed a lady playing dominoes with staff on the day of our visit. At interview she told the visitor that she did not like dominoes yet felt pressurised by staff to participate. On examining this lady's care file, the visitor found this lady's dislike for dominoes documented. The visitor highlighted this anomaly to a member of staff who did not appear to take this matter seriously and was dismissive of the individual's activity preferences. The individual told the visitor she felt fed up and frustrated.

Visitors spoke to some staff who believed that individuals were not interested in taking part in activities. In one ward, a gentleman repeatedly told staff that there was nothing wrong with him and at his age he didn't want to do anything. There was very little in the way of planned activity on the ward. The visitor gained no sense from staff that their lack of knowledge about his past and current hobbies and interests, the poor activity provision on the ward generally and the gentleman's refusal, and lack of motivation, to do anything could be clinically important in terms of his assessment, treatment and preparation for moving beyond the ward setting.

We found the consistency of staffing and frequency of activity provision to be easily sacrificed when the wards were busy. Variable staffing levels and lack of access to other disciplines like Occupational Therapy were also cited by staff as undermining the therapeutic value of activity in preparing people for life beyond the admission ward setting.

Good practice

One individual spoke very highly of the staff saying that when he was admitted to the assessment ward he didn't feel like speaking to anyone or participating in anything. The staff supported him through this difficult time providing him with a variety of his favourite reading materials which he felt helped his concentration. They also spent time with him, *"just being around".* As he began to feel better he took them up on the offer of walks around the hospital grounds …. *"Before I was admitted I hadn't been going out at all. The opportunity to get outside really boosted my confidence."*

Action needed

- **All assessment wards for older people must provide a range of activities that enable people to maintain independent living skills, social engagement and purposeful activity.**

- **All older people in assessment wards must have support to access indoor and outdoor recreational space.**

- **Staff should receive appropriate training about person centred care, communication skills and the selection and provision of appropriate activities for older people.**

- **There should be sufficient financial and other resources, such as equipment, materials, training and facilities, and effective use of the available environment and local community to provide a range of activities.**

PART TWO

Care planning and participation

Why we are interested in care planning and participation.

Recognising the importance of activity and the need for individuals to be included, regardless of their impairments, is essential when encouraging individuals' participation and social interaction.

Recording and using information about an individual's life history is important when including activity in the care planning process. To achieve a positive outcome with planned activity, biographical knowledge combined with information about the individual's current strengths, expectations, wishes and needs is required.
The aim is always to assist the person to function as independently as possible

What we would expect to find

We would expect a good activity plan to be created, followed, reviewed and updated to accurately reflect the individual's needs. As well as reviewing the suitability and adaptability of activities, we would expect important information to be collected about the individual's satisfaction with regard to activity provision. Most importantly we would expect to see the activity plan integrated into the individual's care plan.

What we found

From examining individual's case files and observing the activity culture, the visitors found wide variations in the quality and quantity of recorded information about the activity and social needs of individuals. At one end of the spectrum this comprised no involvement of the individual, relatives or carers, no record of individual's likes/dislikes, hobbies and interests and therefore no mention of how activities could be used in addressing identified needs in the care plan. One carer stated he had never been consulted by any member of staff about his wife's interests or preferred activities, or even just about her in general. The visitor noted,

"There is no documented evidence to show that meaningful activities are embedded in this lady's daily routines and how they could be used to treat her anxiety and depression."

A son told a visitor that in his opinion, his mother was still experiencing a huge sense of loss following the death of her husband a few years previous. The loss had had a significant impact on her wellbeing and day to day functioning yet no-

one seemed to be offering her counselling, or indeed any activities, which might help her to cope prior to and since her admission.

At the other end of the spectrum we saw care planning informed by personal history profiling with input from family and carers to identify the individual's activity choices and preferences.

We found examples of individual's activity preferences being recorded, we witnessed staff consistently engaging with individuals through the use of activity, asking individuals how the activity affected them, varying the levels of support offered to maximise participation but found little of this valuable interaction recorded in case files.

Good practice example

"There is documented evidence of the daughter's concern about the need for her father to be involved in a range of activities to minimise his tendency to withdraw into himself. The occupational therapist has completed an initial interview form on which his self care, domestic and leisure activity preferences are clearly recorded. The nursing plan records the need for this gentleman to participate in a range of daily activities to improve his low mood and reduce his anxiety. The physiotherapist has assessed this gentleman's mobility by taking him for a short walk outdoors and is now involving him in an exercise group to improve his fitness and to provide an opportunity for social interaction. Dental and optician appointments have been scheduled.

A visitor found helpful documented examples of a person with dementia's personal preferences with sensitive and practical advice for all staff involved in his care on how to build rapport and maximise his engagement in everyday activities.

Dislikes having his hands held, do not ask direct questions as he will abandon the activity …. Likes to listen to conversation rather than join in. He particularly enjoys being read to.

Good practice example

An Asian man was experiencing delusions and was socially withdrawn when he was admitted to the ward. His wife spoke no English. An interpreter facilitated communication between the staff and the wife to identify his hobbies and interests. This resulted in the staff sourcing his favourite Indian music. It also helped them identify and locate her husband's friends. One such friend lived elsewhere in the UK and another lived abroad. The staff arranged telephone conference facilities between the three friends to nurture support and meaningful communication.

Action needed

- **Biographical information about the individual must be recorded and kept up to date to inform the care plan and activity provision.**

- **The individual's activity preferences, interests and abilities must be regularly reviewed, and outcomes and satisfaction recorded in the care plan and evident in practice.**

- **Care planning should be person centred, use a range of therapeutic interventions and reflect changes in physical and mental health.**

- **Care plans should be regularly audited to ensure that preferences, interests and abilities are assessed, monitored and reviewed.**

SECTION 3

THE PHYSICAL ENVIRONMENT

KEY MESSAGE

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

We regularly visit NHS admission and continuing care units for both adults and older people. Our reports from these visits consistently highlight concerns about the physical environment in many in-patient units. We often find these environments to be uninspiring and poorly maintained. We have noted that many of these poor reports related to services for older people.

Admission to an assessment ward can result in individuals feeling alone among strangers, distressed as they are separated from family and friends and disorientated being away from familiar roles, routines and objects.

The importance of the contribution of the physical and the psychological environment is well documented and in particular the importance of good building design for people with dementia. The Dementia Services Development Centre at the University of Stirling has produced an audit tool 'Design for People with Dementia' and this has now been adopted by the Scottish Government Health Directorate to support improvements in the design of NHS facilities for people with dementia. The emphasis of this audit tool is to promote "enabling design" and the good practice principles apply equally across care groups as a whole regardless of whether an individual has dementia or not. Our visits to older people in mental health admission wards included people who did have dementia and others who did not.

At these visits we carried out audits of the dining areas, living areas and bedroom areas on the wards visited. In addition we looked at the garden areas and considered some general questions about the ward environment. We wanted to see these for ourselves, as well as gather information and opinions from people on the wards.

We should point out that the buildings that we visited varied from brand new purpose built wards to some hospital wards that had been built in the Victorian era. Even so, we found some older wards where staff had taken time and creatively made the most of the environment, whereas in some new units staff felt inhibited in trying to improve the physical environment. For example they were told they should only use the same signage and decoration as the rest of the general hospital.

GARDEN AREAS

WHY WE LOOKED AT GARDENS

The reasons we looked at garden areas were two-fold.
First, our visitors often hear from people that they find it difficult to spend time off the ward and to get some fresh air, peace and quiet. This is particularly important if someone is detained in hospital and cannot leave the ward when they want to, or if they need help from others to get around. Second, garden areas have the potential to be flexible and creative environments which can be used therapeutically to promote the health and wellbeing of individuals. Having access to and using safe and secure outside space has been shown to have beneficial effects on levels of agitation and distress and provides an often welcome opportunity for a break from the ward environment. We believe that spending time outside is essential for maintaining good mental and physical health. We regard access to outdoor space as an essential component of an assessment ward environment because of the therapeutic value it holds for individuals.

What we would expect to find

Our visitors looked to see if there was an easily accessible and safe garden area that was attractive, well maintained and also if there was evidence that the garden was being used in a meaningful way to support rehabilitation and recovery.

What we found

Of the sixty-three wards we visited, nearly one third did not have an attractive and well maintained, easily accessible and safe garden area for people to use. Some of the wards we visited were on upper floors which meant that often patients would need the assistance of a visitor or a member of staff to be able to reach the garden. In other areas the garden was not easily accessible from the ward because it was difficult to get to or out of sight. For example, after visiting one hospital our visitor commented…

The garden area available to people in the ward consists of some wooden benches and shrubbery adjacent to the hospital entrance. It is used by all patients in the hospital and the ground which at first looked like bark and gravel was actually a sea of cigarette butts. It is entirely unsuitable for older people.

On one occasion when there was a safe and attractive garden area the door to this was locked.

One of our visitors commented:

Exceptionally nice and well laid out garden area but door to it was locked, no-one was using it today despite it being very sunny.

One ward we visited had direct access to a large garden area but this was not well maintained and most of it was gravel which is difficult to move across and dangerous for anyone with mobility problems.

Our visitor to Ailsa hospital commented;

Both wards had access to delightful safe gardens and staff try to get anyone who wants to outside in the garden every day.

We found that when there was a good garden area there was evidence that it was being used regularly.

Action needed

- **Hospitals should ensure that there is an easily accessible, safe and secure garden area that provides multi-sensory stimulation.**

- **Wards for older people should be at ground level.**

- **There should be an inclusive, partnership approach with individuals and carers, voluntary organisations and healthcare professionals to enable individuals to use outdoor environments creatively and flexibly.**

DINING AREAS

Why we looked at dining areas

We were particularly keen to look at where people took their meals and if the dining areas promoted a relaxing and enjoyable meal time.
A good dining environment can encourage a person's interest in their meals and help to meet nutritional as well as social needs.

What we would expect to find

We would expect to find an adaptable dining area where all attempts had been made to minimise noise and make the environment a pleasant and relaxing place to be. We expected to find that people would be given a choice in what they were offered to eat and given the level of assistance that they required.

What we found

The majority of wards that we visited provided good dining room facilities that allowed for easy access. We found attempts to create positive dining experiences and suitable tables for wheelchair users. Only a few sites scored poorly in this area mainly due to wards sharing one small dining area. In one of the areas that scored poorly the dining room was described as a corridor that acted as a thoroughfare through the ward.

Action needed

- **All wards must have dedicated spacious and adaptable dining areas that can afford people the assistance they need or promote their independence.**

BEDROOM AREAS

Why we looked at bedroom areas

Bedroom areas can provide quiet, personal and private space in which to retreat from a busy ward environment**.**

What we would expect to find

People should have an easily identifiable, personalised area in the ward that affords privacy and allows space for personal belongings.

What we found

Many of the wards that we visited did not provide single rooms and most wards were a mixture of dormitory areas and some single rooms. Despite this we were looking to see if the person's individual room or bed area was personalised, protected, easily visible, identifiable and secure. We were also looking to see if the room had easy access to toilet facilities and if there was adequate storage space for personal belongings.

Fewer than half of wards visited had rooms or bed areas that were personalised and looked as though any effort had been taken to make them identifiable to the occupant. Just over half of rooms had access to en-suite toilet facilities.

We found some wards where the practice of locking bedroom doors during the day continues. We were told that this is because some people may interfere with the personal belongings of others but we found other wards where although the potential for this existed the bedroom doors were kept open. In areas where doors were locked because of the potential for other people to interfere with belongings we found nothing to aid the person's orientation to their own space e.g. family photographs or identifiable personal belongings.

On one ward we visited we were told by the charge nurse that as people were only admitted for an average of five weeks that they felt there was no need to personalise the bed area. At this visit though we found a patient having difficulty finding her bed area - she told the Commission visitor that everywhere looked the same.

Personalisation of rooms in any way was usually left for relatives to do. We often found that people's names were handwritten or typed onto small pieces of paper and placed on the locker beside the bed. In one area these had then been put into a polythene pocket and the reflection from this made it almost impossible to read the name.

Action needed

- **All assessment wards must ensure that individual's bed areas are personalised, recognisable and offer privacy and dignity.**

SIGNAGE

Why we looked at signage

It is essential that people are able to find their way around as easily as possible and this is particularly important when an older person is admitted to hospital. Even for people who do not have dementia, a hospital ward can be a difficult place to find your way around and disorientation and frustration can interfere with the assessment and treatment process.

What we would expect to find

We would expect all mental health admission wards for older people to have clear signs at appropriate heights, large print signs and pictures on walls and doors so that people can easily find the toilets and bedrooms.

What we found

During our visits we paid close attention to the signage on the ward. We were particularly interested to know if there was good signage to identify toilet areas and communal areas. In the majority of wards we visited we found that the signage was poor.

We were told in one ward that they previously had more signage but it just kept getting ripped off and so they had stopped replacing it.

In one ward the Commission visitor commented that the signage was poor and was told by a staff nurse that this was intentional, to encourage the person to orientate without the aid of any cues and also to assess their level of disorientation.

We found some examples where staff had been trying to make improvements. In the Western Isles Hospital they have already carried out their own audit of the environment and have identified that improved signage is needed. In Blairgowrie Hospital our visitor noted

'Although not designed as an admission ward, everything has been done to make it dementia friendly in line with Stirling guidance, including very good signage'.

On one ward in a very new building managed under Private Finance Initiative we were told that staff were not allowed to put any additional signage or pictures onto the walls and that this was because the 'owner' would not allow this.

Action needed

- **All wards must have environmental cues and signs to assist orientation. The Dementia Services Development Centre at the University of Stirling has an audit tool that can help and all NHS boards have staff trained in the use of this tool. NHS Boards must make use of this valuable resource.**

SECTION FOUR

OTHER THINGS WE LOOKED AT

MULTI-DISCIPLINARY CARE REVIEWS

We asked who attended multi-disciplinary care reviews. We were interested in this because we believe that a partnership approach with people, their carers and a wide range of social and health care professionals is essential. This ensures a comprehensive assessment of the individual that considers their physical, psychological and emotional needs.

Many older people admitted to assessment wards are likely to be living with more than one long-term condition and we would expect individuals to have access to a comprehensive multidisciplinary assessment.

We found that reviews limited to medical and nursing input were much more common for people in dementia assessment wards. We found multi-disciplinary reviews confined to only nursing and medical input in half of all dementia assessment wards. Most review meetings in functional assessment and combined dementia and functional assessment wards involved other disciplines and the person and /or their relative or advocacy worker attending. Other disciplines would normally include social work, occupational therapy, psychology and physiotherapy amongst others.

MIXED SEX WARDS

Of the wards we visited, the vast majority admitted both men and women and only six were single sex wards.

We thought that we might hear some strong views against mixed sex wards from people but this was not in fact the case.

When problems were reported these tended to be about some people displaying sexually inappropriate behaviour or misidentifying another person as their spouse. Staff in wards where there was good single room provision described this as easily managed in conjunction with appropriate levels of observation.

Staff in wards with dormitory type accommodation thought that having enough staff to ensure appropriate levels of observation was essential to ensure privacy, dignity and safety.

All wards we visited had taken steps to ensure privacy and dignity by providing separate sleeping, toilet and bathing facilities for men and women.

We received several comments from staff about the benefits of mixed sex wards including increased social interaction and a sense that this was a reflection of how we live anyway.

COMBINED DEMENTIA ASSESSMENT AND FUNCTIONAL ASSESSMENT UNITS

We visited twelve assessment wards that admitted both people with dementia and people with functional illness. Of these wards, six were sited in a general hospital, four in a psychiatric hospital and two in a remote cottage or community hospital. We asked staff if they found any particular problems with this and how they managed to overcome these.

We were told that the main problem tended to be that some people with dementia misidentified their personal belongings and could also invade the personal space of other people.

We found that in wards where there was adequate living space and single bedroom accommodation fewer problems were reported, and privacy, dignity and safety was less likely to be compromised.

Providing activities that would be stimulating and meet the needs of each individual was cited as challenging and we discuss this in further detail in Section2.

LENGTH OF ADMISSION AND DELAYED DISCHARGE

We often hear concerns about lengthy hospital admissions and the negative effect this can have on an individual.

A lengthy period of time in hospital can undermine a person's confidence and independence and can help encourage an unnecessary dependency on others.

We would expect that nursing staff would be able to give us details of cases of delayed discharge and the reasons for this. We would expect that when someone's discharge is delayed that this is closely monitored to lessen the potential negative effect on them.

On all wards we visited we asked about the average length of admission.

Dementia assessment wards visited tended to have a longer average length of stay at 11 weeks compared with about 10 weeks for functional assessment and mixed dementia/functional assessment wards. There was however a wide variation with some wards reporting an average of only 4 weeks and some up to 24 weeks.

We also asked about the number of people whose discharge was delayed. By that we explained that we meant people who had been declared medically fit for discharge but for whatever reason had not been discharged from the ward yet. (We should point out that the information on the number of delayed discharges we give is based on what the nurse in charge told us on the day of the visit and this may vary from statistical information provided by the individual Health Board areas).

We found that the average number of people seen as delayed discharge on dementia assessment wards visited was 2.5 and 0.75 on functional assessment wards. The number for mixed functional and dementia assessment wards was 3.

We asked staff the reasons for these delays. We were told that across all wards the main delay was when people were waiting to move onto a care home but their first choice of care home was not currently available and they were waiting on the ward until they could move there. We also found that a large number of people were considered delayed discharge because there was a lack of an appropriate specialist care provider. This was usually a care home that was considered best able to look after people who had dementia but also some challenging behaviours. We also found that in dementia assessment wards, in around 1 in 10 people seen as delayed discharge were waiting to transfer to an NHS continuing care bed but none was currently available.

Both functional and dementia wards also had about one in ten people seen as delayed discharge because an application for a welfare guardianship order had been made but discharge could not happen until this was approved.

DISCHARGE AND PREVENTING READMISSION

The Commission often visits people who live in care homes. Sometimes we are told that it may have been possible for the person to remain in their own home if more help and support had been available to them. We were keen to hear from people what services made it more likely that someone would be able to return to their own home.

We were told about various things that are often helpful.

We heard in one area that staff felt that older people were disadvantaged compared to younger adults because there is no intensive home treatment team available for older people. Some areas also told us that there was a maximum amount of home care support that someone would receive before the local authority would consider the care package too expensive.

In another area we heard that the local authority social work department will provide home helps or carers up to four times a day but no more than that limit.

However, we did hear from some staff that even when a full care package is in place it cannot provide the level of support to counteract the social isolation and loneliness which precipitates many admissions. We heard from people that befrienders, as well as formal carers, were very important particularly for people with dementia, we heard that some day centre support for people, particularly lunch groups and drop in centres are closing and that this limits social support for people.

Night-time was described as a particularly difficult time for people to get the help that they need. Often someone may just need reassurance or checking but at night-time this can be difficult to arrange. Staff described difficulties if someone suffers from “night-time wandering”.

We heard from staff in different areas that the traditional style day hospital had previously been viewed as a valuable resource for people and helped to maintain people in their own homes for as long as possible though many of these had closed or were facing closure.

The benefits of new technology have been well promoted recently and staff are now more likely to give consideration to the use of technology in enabling someone to return home. In one area we heard about a delay in getting some telecare aids such as active mats, buzzers and SMART technology

Some of our visitors were surprised that nursing staff in many of the wards we visited had themselves not visited the care homes that people often move on to. Some staff did though have regular contact and where this was happening we were told that care home placements were usually successful and met the needs of the individual.

Throughout the country we heard about a lack of specialist care home provision, usually for people with dementia who have associated challenging behaviours. We were told that often people would move on to NHS continuing care facilities when this would not have been necessary it there had been specialist local care home provision.

Acknowledgements

In addition to all those who met with us on our visits we would particularly like to thank the Dementia Services Development Centre at Stirling University for allowing us to use their audit tool and Alison Tullis, Head Occupational Therapist, Royal Edinburgh Hospital, NHS Lothian for providing training and guidance in its use.

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Caring and consent, Information for carers. Health Rights Information Scotland, 2009

Consent: Patients and doctors making decisions together, General Medical Council, 2008

Design for People with Dementia: Audit Tool, Dementia Services Development Centre University of Stirling, 2009

Food, fluid and nutritional care in hospitals, NHS Quality Improvement Scotland, 2003

Mental Health (Care and treatment) (Scotland) Act 2003

Older and Wiser, Mental Welfare Commission for Scotland, 2007

Useful links

www.cot.org.uk (College of Occupational Therapists - activities for older people)

www.thrive.org.uk (therapeutic horticulture)

www.trellisscotland.org.uk (therapeutic horticulture in Scotland)

www.napa-activities.co.uk (National association for providers of activities for older people)

www.petsastherapy.org (lists local organisers)

some more websites for inclusion in the reference section

www.csp.org.uk (chartered society of physiotherapists - easy exercise guides)

www.bda.uk.com (british dietetics association - leaflets/guides on nutrition for elderly people, food facts re healthy snacks)

www.baat.org (british association of art therapists including links to Arts Therapies Professional Bodies - art, music, drama and dance movement)

Appendix 1 LIST OF HOSPITALS AND WARDS VISITED

PSYCHIATRIC HOSPITALS

Hospital	Ward	Functional assessment(F) dementia assessment(D) or both(B)	Mixed(M) or single sex(S)	Number of beds
Ailsa	Croy	F	M	14
Ailsa	Dunure	D	M	22
Argyle and Bute	Cowal	D	M	15
Royal Cornhill	Davan	D	M	20
Royal Cornhill	Fraser	F	M	25
Royal Cornhill	Skene	F	M	26
Crichton Royal	Cree West	D	M	14
Crichton Royal	Glencairn	F	M	15
Gartnavel Royal	Cuthbertson	D	M	20
Gartnavel Royal	Timbury	F	M	25
Herdmanflat	Lammerlaw	B	M	24
Leverndale	Balmore	D	M	18
Leverndale	Banff	F	M	24
Royal Dundee Liff	Ward 21	D	S	17
Royal Dundee Liff	Ward 22	D	S	17
Murray Royal	Garry	D	M	12
Murray Royal	Leven	F	M	14
Murray Royal	Tummel	D	M	12
New Craigs	Clava	D	M	20
Parkhead	Ward 2	F	M	16
Parkhead	Ward 6	D	M	21
Rosslynlee	Ward 2	B	M	26
Royal Edinburgh	Eden	F	S	24

Royal Edinburgh	Ward 14	D	S	18
Stratheden	Drumcarrow Lodge	B	M	8
Sunnyside	Ward 13	D	M	15
Sunnyside	Ward 5	F	M	12
Whyteman's Brae	Torbain	B	M	22

GENERAL HOSPITALS

Hospital	**Ward**	**Functional assessment(F) dementia assessment(D) or both(B)**	**Mixed(M) or single sex(S)**	**Number of beds**
Airbles Road	Colville	F	M	16
Royal Alexandra	Ward 37	D	M	20
Royal Alexandra	Ward 39	F	M	20
Ayrshire Central	Pavilion 1	D	M	18
Ayrshire Central	Pavilion 2	F	M	18
Borders General	Cauldshiels	D	M	20
Coathill	Glen Nevis	D	M	10
Coathill	Glen Orchy	D	M	10
Falkirk	Ward 17	B	M	30
Hairmyres	Ward 19	B	M	5*
Inverclyde	Ward 4	B	M	20
Queen Maragaret	Ward 1	B	M	24
Royal Victoria(Edinburgh)	Ward 1	D	S	23
Royal Victoria(Edinburgh)	Ward 2	B	S	16
St John's	Ward 3	B	M	24
Stirling Royal	Ward 30	B	M	26
Stobhill	Ward 43	D	M	14
Stobhill	Ward 44	F	M	16
Udston	Brandon	D	M	24
Udston	Clyde	F	M	20
Vale of Leven	Christie	F	M	6*

Vale of Leven	Fruin	D	M	12
Western Isles	Clisham	D	M	28
Wishaw General	Ward 3	D	M	23

COMMUNITY/COTTAGE HOSPITALS

Hospital	**Ward**	**Functional assessment(F) dementia assessment(D) or both(B)**	**Mixed(M) or single sex(S)**	**Number of beds**
Banchory	Scolty	D	M	18
Blairgowrie	Strathmore	D	M	12
Bonar Bridge	Upper floor	B	M	12
Campbell, Portsoy	Findlater	D	M	8
Crieff	Ward 1	D	M	10
Invergordon	Fyrish	D	M	12
Inverurie	Ashcroft	D	M	15
Pitlochry	Athol	D	M	7
St Vincent	Lynwilg	B	M	12
Ugie	Buchanhaven	D	M	**20

* situated in adult general admission ward
** includes some continuing care beds