Mental Welfare Commission for Scotland

Report on announced visit to:

Willow Ward, Ferryfield House, 100 Pilton Drive, Edinburgh, EH5 2HF

Date of visit: 21 August 2023

Where we visited

Willow Ward is a 30-bedded unit for older adults with a diagnosis of dementia who have complex care needs. It is one of two NHS hospital-based complex clinical care (HBCCC) wards based in Ferryfield House, the other ward being primarily for frail, older adults with physical health care needs.

Ferryfield House is a 60-bedded one-storey building. Opened in 1996 as part of the private finance initiative, it is owned and managed by Walker Healthcare. The building and domestic services managers, provided by the management company, run on-site services, including catering and laundry.

We last visited this service in November 2018 and made no recommendations. During the intervening period, the Commission maintained contact with the ward for updates, particularly during the height of the Covid-19 pandemic. We heard about the significant challenges of Covid-19 on patients and staff, as well as the impact of visiting restrictions for carers.

We had also been made aware of the re-design of older people's mental health services in Edinburgh. In the previous year there has been a reduction in the number of HBCCC wards from four to three, and a gradual move of two of the three wards from mixed-sex to single-sex.

The plan was that Willow Ward would admit only female patients, with Prospect Bank Ward at Findlay House admitting male patients.

Bed numbers had been capped at 21 for some time due to staffing capacity. On the day of our visit the ward was full, however 19 of the 21 patients were female.

On this visit we wanted to meet with patients, carers and staff to find out about their experiences of the service post-pandemic.

Who we met with

We met with and reviewed the care of five patients. We also spoke with three relatives.

We met with the service manager, the senior charge nurse and other members of the nursing team. We also spoke with the psychologist and activity co-ordinator.

Commission visitors

Juliet Brock, medical officer

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

When we last visited the service, the feedback we received from relatives was very positive. On this visit the views from relatives were more mixed.

Relatives viewed the care on the unit as generally good, “staff on the whole are lovely”, but also raised specific issues, including the attitude of some staff. One person described feeling very upset after visits to the ward, but told us the senior charge nurse had been very supportive.

There was a perception among relatives that there was not enough staff on the ward. We also heard comments that there had been a lot of staff changes and that the use of agency staff was noticeable.

Some relatives felt there was poor communication from the team, describing a lack of participation in their loved one’s care and not being invited to meetings, including discharge planning meetings. Senior staff told us that relatives should always be invited to the three-monthly review meetings.

One person also shared concerns about their relative’s personal care, which they felt should have been better. Where carers shared specific concerns, we raised these with senior staff on the day and gave advice about carer support and about making a complaint if they wished.

A few patients were able to speak with us about their experiences. They told us that the care from staff was okay but that the ward was often noisy.

We heard from managers that the previous few years had been very challenging for the team. There had been a lot of changes in senior staffing on the ward, in addition to staff shortages. We were told that there was frequent use of bank staff, but that a regular cohort of bank staff had helped to provide continuity during this difficult time.

Multidisciplinary team (MDT)

The unit had a range of disciplines either based on site or accessible to them. The nursing team on the ward had been joined by an advanced nurse practitioner, a new part-time role created to support the team. We were told that a nurse with a role in quality improvement was also working with the staff.

Medical input was provided weekly by a consultant psychiatrist, who also carried out three-monthly reviews, and by a resident doctor working across the two wards during the week to supports patients’ physical health care.

Since we last visited there had been a change in occupational therapy (OT) support to the service and there was no longer regular OT input to the ward. OT input was now only available on referral for assessment. We were pleased to note that the activities co-ordinator post remained and that the new person in post was assisted by a part-time support worker. We heard that collectively, this small team had made significant progress in progressing the activities programme for patients on the ward.

The MDT was now also supported by a psychologist, who had been in post and developing the role over the previous year. They were also being supported by a trainee. The psychologist told us about their work with the ward staff to develop formulations and how they helped to support individualised care planning. They were working with patients who were new to the ward and who were experiencing stress and distressed behaviour, using the Newcastle model.

Input from physiotherapy, dietetics, speech and language therapy were all available on referral, but we were told that this could take a while.

There was a social worker based on site, who had input to the MDT. At the time of our visit three patients were categorised as delayed discharge, due to delays in court hearings to consider applications for welfare guardianship.

Care records

The majority of patient records were stored electronically on the patient management system TRAKcare, a change since our last visit and a system that is in keeping with other services across NHS Lothian.

A range of documents were still held on paper files. These included 'Getting to know me' forms, copies of legal documents relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 and Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and Do not attempt cardio-pulmonary resuscitation (DNACPR) forms, which were up to date and appropriately authorised in the files we viewed.

We found that the day-to-day recording by nursing staff of patient progress on TRAKcare was of poor quality. Care entries lacked detail, were very task-focused and were not strengths-based. We were also concerned by the use of critical and judgemental language in some individual entries we viewed. We did not see evidence of regular one-to-ones by keyworkers. We were told by senior staff that this was currently an area of focus for staff training and quality improvement work.

In contrast, we saw good recording in the notes by other members of the MDT. The detailed entries by the music therapist in particular were exceptional. The activity workers, who had only recently begun recording in patient files, also provided meaningful updates of individual contacts and patient participation in groups. There was evidence of psychology assessment, detailed chronology and review for some individual patients. We also saw evidence of input from dietetics and robust physical health reviews by medical staff.

The recording of MDT meetings varied in quality. Long term plans for individual patients were sometimes unclear and there was a lack of evidence of social work input. Participation from patients or their relatives was absent in the reviews we looked at. We also noted a lack of documentation regarding patient rights. This was a theme we had noted in MDT records across multiple wards in NHS Lothian and which we have recommended is added to future recording.

In the files we reviewed, we found the care plans to be of a variable quality. We saw a few examples of very good person-centred care planning, with evidence of patient involvement. Many care plans, however, had little personalised detail, were repetitive, and offered little

information regarding individual interventions. This included some care plans we saw for continuous interventions, which lacked meaningful detail. Many care plans also lacked positive reflection and there was an absence of a strengths-based approach. Care plan reviews were either poor (for example simply repeatedly stating “no change”) or absent.

Recommendation 1:
Senior managers should regularly audit the case records as part of the current quality improvement work, to ensure more consistent, meaningful recording of patients’ day to day progress.

Recommendation 2:
Senior managers should regularly audit nursing care plans to ensure more consistent, person-centred care plans that are regularly and meaningfully reviewed.

Use of mental health and incapacity legislation

On the day of our visit, 11 of the 21 patients in the ward were detained under the Mental Health Act. All but one of these patients were subject to a compulsory treatment order.

Copies of all documentation pertaining to the Mental Health Act and the AWI Act, including certificates around capacity to consent to treatment, were in place in the paper files, although not always accessible electronically on SCI store in TRAKcare in some of the individual records we reviewed.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Certificates authorising treatment (T3) under the Mental Health Act were in place where required. These corresponded to the medication being prescribed, with a few exceptions. We liaised with the responsible medical officer following the visit to ensure prescribing was reviewed and that all medication was properly authorised.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker, and record this on the form. We found copies of section 47 certificates in the paper files we reviewed, however one was not accompanied by a treatment plan and another granted indefinite authority, which we do not recommend to be best practice.

Recommendation 3:
Senior managers should ensure that a system is in place to regularly audit the authorisation of medical treatment under both the Mental Health Act and the AWI Act, to ensure that all treatment being given to patients on the ward has the proper legal authority in place.

Rights and restrictions

The patients who were able to speak with us were not aware of their rights and we did not see reference to advocacy support in the records we viewed.

Staff told us that AdvoCard provided advocacy support on a referral basis and that three patients on the ward were receiving ongoing advocacy support at the time of our visit. We recommend that information is made available for patients on their rights as appropriate.

As discussed previously, although a number of patients were able to engage in discussions about their care when we visited, we did not see evidence of their participation in MDT reviews or consultation to ascertain their views.

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/law-and-rights/rights-mind

We noted that, contrary to our last visit, there appeared to be a lack of information and support available for carers. We discussed this with senior staff on the day and suggested they might consider options for offering carer support, such as that previously provided in conjunction with the Edinburgh Carers Council.

Activity and occupation

We were pleased to note that the positive progress made on activities noted on our previous visit had continued, in spite of staffing challenges. The activity coordinator and support worker were enthusiastic and creative, and there was clear evidence in the notes that patients were participating in activities. We particularly noted efforts being made to engage those who were either very physically disabled or who were experiencing severe mental health difficulties at the time.

The activity co-ordinator showed us the ward activity planner for the coming month, with a diverse range of activities on offer. These included one-to-one and small group sessions, in addition to regular ward groups that were on offer. We heard from staff and relatives that patients particularly loved singing and music, and that the weekly visits from the music therapist were well attended. There was also regular visits from a therapet.

Regular outings for small groups were arranged and we saw photos of these on the ward. Trips that had taken place included outings to the Botanic Gardens, Portobello beach and the cinema, as well as the Edinburgh Festival Fringe. Staff used taxis for these small group visits. The activities team were also liaising with Edinburgh Leisure with a view to providing swimming trips for patients in the future. The team were also looking to introduce playlist for life for patients on the unit.

Staff on the ward also collaborated with the activities team to provide themed days, providing additional engagement for patients who were unable to go out of the unit. These had included celebration days and tea parties, with patients making decorations, staff dressing up in costumes, and the catering team providing a special menu for the occasion.

The physical environment

We found the ward to be ward bright, welcoming and spotlessly clean, which patients also commented on. The central atrium that provided seating, was a popular space for patients to spend time. Visual interest was provided by pictures and handmade seasonal decorations on the walls.

In the corridors there was good signage, in addition to artwork and items of interest on the walls. Information, such as a menu board and orientation board that was updated daily to help orientate patients to time, was also displayed in the main corridor.

Willow Ward had 27 bedrooms. Two of these were large double rooms, available for use by those requiring disabled access. All rooms were en-suite with a washbasin and toilet. Bedrooms were accommodated along three corridors, spanning from a central atrium. Bedroom doors were decorated as front doors and were clearly signed with patients' names. Patients were able to personalise their rooms with photos and keepsakes and individualised information was displayed from patients' What matters to me document.

On our last visit there were two assisted bathrooms and one wet room on the ward. We were told at the time that most patients preferred to shower, and in response to this, building managers had been asked to redesign the bathrooms to provide more showering facilities. These renovations were planned for 2019. On this visit we noted there were now two wet rooms and one assisted bathroom. The bath was broken at the time, with a new one awaited.

Each corridor had a separate sitting room with TV, adding to the availability of space for patients to use. Other shared spaces on the ward include the large dining room, with attached conservatory and small patio. We were told that families continued to enjoy visiting in these spaces and that special celebrations, such as birthdays, could be held for patients and their families in these spaces.

The dining room had a piano, which was used for music groups and sometimes by individual patients. There had also been recent additions such as a virtual aquarium, providing added visual interest.

The outdoor space on the unit included the small courtyard and a large, enclosed garden. Both spaces had been thoughtfully designed with seating areas, planting, and items of interest, such as birdhouses and feeders, and plants chosen to enhance patients' sensory experience. The garden was well maintained, and we were told it was well-used by patients and their families.

On the last visit we were informed by managers of imminent plans to transform a room in the main reception area into a dementia café. This new Ferryfield Hub was to incorporate a kitchen and provide a space for families to visit their relative away from the ward environment, as well as a family friendly space more suitable for children visiting. We were pleased to see the Welcome Hub complete on this visit, with staff and families reporting that this was a welcoming and well-used space.

Summary of recommendations

Recommendation 1:
Senior managers should regularly audit the case records as part of the current quality improvement work, to ensure more consistent, meaningful recording of patients' day to day progress.

Recommendation 2:
Senior managers should regularly audit nursing care plans to ensure more consistent, person-centred care plans that are regularly and meaningfully reviewed.

Recommendation 3:
Senior managers should ensure that a system is in place to regularly audit the authorisation of medical treatment under both the Mental Health Act and the AWI Act, to ensure that all treatment being given to patients on the ward has the proper legal authority in place.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

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

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk