Mental Welfare Commission for Scotland

Report on announced visit to:

Prospect Bank Ward, Findlay House, 5 Seafield Street, Edinburgh, EH6 7LN

Date of visit: 24 July 2023

Where we visited

Prospect Bank Ward is an NHS hospital-based complex continuing care (HBCCC) unit providing care for older adults with a diagnosis of dementia who have complex care needs.

Prospect Bank is one of two NHS wards that comprise Findlay House, a single-storey unit based on the former Eastern General Hospital site. The building is owned and managed by a private company as part of a private finance initiative (PFI), with meals, laundry and domestic services provided by NHS Lothian.

Originally designed as a 30-bedded unit, patient numbers on Prospect Bank Ward were previously capped at 21, and since our last visit this had been further reduced to 19 beds.

NHS Lothian currently has three mental health HBCCC units for over-65s in Edinburgh. In recent years the Commission has been made aware of a number of proposals to re-design the older people's mental health service. These included plans to move existing HBCCC units (including Pentland ward, a fourth HBCCC unit which was based at the Royal Edinburgh Hospital) to a different site. However, this move did not take place as planned and Pentland Ward closed at the end of 2022 (amalgamating instead with Canaan Ward, a male dementia assessment ward in the Royal Edinburgh Hospital).

We were told that other service changes had progressed during this time, with two of the three remaining HBCCC units gradually changing from mixed sex to single sex wards. Prospect Bank has moved towards becoming an all-male unit. Meanwhile, during a parallel transition, Willow Ward, based at Ferryfield House, has been gradually admitting more female patients.

At the time of this visit there were 19 patients on the ward, six of whom were female.

We last visited this service in November 2018, when Prospect Bank was one of four national demonstrator sites participating in the specialist dementia unit improvement programme, a Healthcare Improvement Scotland (HIS) initiative.

The team were undertaking a range of quality improvement projects as part of the pilot at the time and the Commission visit was positive, with only one recommendation made in relation to the authorisation of treatment for patients detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act).

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.

On the day of this visit we wanted to meet with patients, carers and staff to find out about their experiences of the service post-pandemic and to hear about the outcome of the dementia pilot and quality improvement work.

Who we met with

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

We spoke with the clinical nurse manager, senior charge nurse and charge nurses.

Commission visitors

Juliet Brock, medical officer
Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

The feedback we received from the relatives we spoke with was overwhelmingly positive; they felt their loved one was well cared for in the unit and very complimentary about the staff. Comments included "they're just fantastic, they're lovely people, I'm so grateful to them" and "staff are busy but they take good care of him, he's well looked after", while another carer spoke of feeling reassured when they left the ward after each visit knowing their spouse was "in safe hands" and having "peace of mind that [they] will get the best care they need".

Carers said they felt welcome on the ward and told us there was good communication from nursing and medical staff. They said they were involved in discussions about their relatives' care and treatment, and were regularly invited to review meetings.

Multidisciplinary team (MDT)

The multidisciplinary team comprised nursing staff, including a new trainee advanced nurse practitioner (ANP) and the consultant psychiatrist. Additional medical support was provided by a team of clinical fellows who covered both wards in the building and attended to patients' physical health needs.

Since our last visit, a psychologist had been appointed, but there was no psychology input available at the time of our visit due to maternity leave (for which cover was being recruited). There was also no activity co-ordinator at the time of our visit due to long term absence. We were told that an additional post had been created, but that recruitment had been unsuccessful. Unlike the previous visit, when there was an occupational therapist (OT) and OT assistant in the MDT, there was no OT input to the service at the time of this visit. Referral for an individual OT assessment had to be made to the team at the Royal Edinburgh Hospital and we were told this was rarely done for the patient group. A music therapist visited one day a week.

The ward had input from a pharmacist as well as a dietician, who visited weekly to offer support and advice. Referrals could be made for physiotherapy and speech and language therapy when needed.

Findlay House has a designated social worker, managed by Edinburgh City Council, who forms part of MDT. We were told that much of their focus was in supporting the discharge of patients on the physical health ward.

At the time of our visit there were six patients subject to delayed discharge on Prospect Bank Ward. The ward did not have a waiting list for admissions, but two patients had been boarded to Canaan Ward at the Royal Edinburgh Hospital due to the service being at capacity.

As is a common finding in mental health teams across Scotland at the present time, staffing levels were also a concern for the service. We were advised of a number of unfilled vacancies for both nursing staff and healthcare assistants. We noted however that the number of vacancies for registered nurses had reduced from nine on our last visit to six on this visit. Senior nurses told us that they often relied on bank and agency staff. We heard that there was a core group of nurses on the staff bank who knew the ward well, but that bank shifts were

not always filled. We were advised that the senior nursing team were very visible on the ward to support ward staff and that 'safety huddles', supported by the service manager, took place twice daily.

Care records

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

Only a limited number of documents were still held on paper files, including 'Getting to know me' forms, copies of legal documents relating to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or Adults with Incapacity (Scotland) Act 2000 (the AWI Act) and 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms, which were all in order and properly authorised in the files we viewed.

The day-to-day recordings of patient progress on TRAKcare varied in quality. We found that many of the care entries lacked detail. Some, but not all staff used canned text, which prompted recording of varied aspects of patient care and appeared to improve the quality of recording. There was also limited evidence of patients' participation in activities in the day-to-day records. An exception to this was the music therapist, whose record keeping was of a high standard and communicated detailed information about each individual patient and how they engaged, even where the person's ability to participate in music therapy sessions was limited.

We were concerned by the lack of recording of MDT meetings in the clinical record. We could find no record in individual patients' files of the person's MDT review, progress or plans for future care in between their three-month review meetings. We spoke with senior staff about this and were told that weekly discussions did take place, but the records were not held in patient files and could not be easily accessed as summaries but were communicated via email. The three-month reviews were documented in the patients' records, but we found these varied in quality in the files we reviewed, and often lacked detail and a clear action plan.

Care plans

The individual care plans we viewed were generally detailed, person-centred and included some evidence of review. We saw care plans that were linked to the person's 'Getting to know me' summary, including their likes and interests and that there had been family involvement in developing the care plan. We also noted that a number of patients had stress and distress care plans and formulations that had been developed with psychology whilst they were in the Royal Edinburgh Hospital, which helped inform their ongoing care.

We were pleased to hear again on this visit that all staff had received training in the management of stress and distressed behaviours. This had been a key outcome of work carried out during the HIS dementia care programme pilot.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Senior managers should ensure a system for recording MDT meetings is established so that these discussions are recorded in individual patients' records.

Use of mental health and incapacity legislation

The ward kept a folder with copies of legal documents for all patients in one place. We thought this was useful and provided an easily accessible reference for all staff.

Only one patient was detained under the Mental Health Act at the time of our visit. We found copies of Mental Health Act documentation as appropriate and their medical treatment was properly authorised on a T3 certificate.

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 AWI Act. We viewed patients' prescription charts on the electronic prescribing system HEPMA and the AWI Act s47 consent to treatment certificates in the legal folder. We found that s47 certificates were in place for the patients we reviewed and were accompanied by individual treatment plans.

We also noted the ward had a file for covert medication paperwork, with copies of the covert medication pathway in place for patients who required covert medication. The pathway documents had been completed for these patients and we saw evidence of review and of the documentation being updated with new medication when required.

Where patients had a welfare guardian or power of attorney in place under the AWI Act, we found copies of these documents in the legal folder, ensuring staff were easily able to check the proxy powers in place when required.

Rights and restrictions

We were concerned to note that there was no access to advocacy for patients on the ward.

In relation to carer support, we heard that input previously provided by Edinburgh Carers Council was no longer in place. Staff ran a carer support group one evening a week, though we were told that attendance was very limited. The staff team did however describe a good relationship with relatives and the provision of individual advice and support when required.

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

Recommendation 2:
Senior managers should ensure there is access to appropriate independent advocacy for patients on the ward.

Activity and occupation

In comparison with our last visit, when the appointment of an activity co-ordinator had transformed the activity programme on the ward, it was disappointing that activity provision appeared lacking at the time of this visit, particularly as this had been a significant focus of quality improvement work during the dementia pilot.

From carer feedback, we heard about the enjoyment and positive impact music therapy had during the weekly session, and we saw evidence in the records of the music therapist's strengths-based approach.

The ward had visits from a therapet and a weekly visit from Elderflowers, a charity providing art practitioners who visit people with dementia, offering engagement through music, singing and mime. We also heard about a number of volunteers, recruited via the volunteer hub, who visited the ward several days each week, offering one to one time for individual patients.

There was access to 'playlist for life', and some patients had playlists compiled. The ward had also recently purchased the digital therapy system RITA (Reminiscence Interactive Therapy Activities) which staff were learning to use.

Although there were opportunities for activities, it was evident that staff shortages and the lack of input from an activity co-ordinator and OT meant that this was limited at the time of this visit. Managers were hopeful that the situation would improve in the future.

The physical environment

The ward environment was light, bright and very clean. It was fairly well maintained, with the exception of a few well-used areas that could have benefitted from being refreshed and re-painted.

We were pleased to see further additions since our last visit and, in particular, large decorative noise reduction panels had been installed in the dining room and atrium. These well-used spaces had previously become very noisy, sometimes increasing the levels of distress for some patients. The introduction of the panels had been one goal from the dementia pilot. We heard that the panels had significantly improved noise levels in these areas; the chosen designs also provided visual interest.

Another area of improvement work had been to create a more personalised environment on the ward. We saw evidence of this on the visit. In the communal dining room and large lounge area the décor, light fittings, window dressings and furniture had been updated to create a relaxed and homely environment. The addition of objects of interest, including a new virtual aquarium, enhanced the therapeutic environment.

Around the corridors there was good use of signage as well as pictures and a bus stop.

The ward design consisted of three bedroom corridors radiating from the central atrium. The atrium remained a popular place for patients to sit and with the new panels, was a calm and inviting space.

Bedrooms could be personalised with pictures and personal items and patients were allowed to bring their own bedding if they wished. Each room had an en-suite toilet and washbasin. A shared bathroom was provided in each corridor.

The large, enclosed garden provided an inviting outdoor space for patients and their relatives to enjoy. Patients had to be accompanied in the garden due to falls risks. The garden was well maintained, with areas of planting, seating areas and a gazebo. We were told that an awning was due to be installed, to offer additional areas of shade during the summer.

During the last visit we were told of plans to convert an old kitchen area in the building's main reception area into a dementia café for patients and relatives to use. Architects' plans had been completed at the time. On this visit we were advised that plans for this dementia café had not been able to progress due to other demands for this space. There were no further plans for establishing a dementia café on the site.

Any other comments

As on the previous Commission visit, we would wish to note that despite the staffing challenges the service continued to have, morale in the team appeared good, the staff were knowledgeable about the patients in their care and there was a high level of engagement with carers, with feedback from the relatives we spoke with being very positive.

Summary of recommendations

Recommendation 1:
Senior managers should ensure a system for recording MDT meetings is established so that these discussions are recorded in individual patients' records.

Recommendation 2:
Senior managers should ensure there is access to appropriate independent advocacy for patients on the ward.

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.

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