

VISIT AND MONITORING REPORT

Themed visit to  
people with  
dementia in  
community  
hospitals

MAY 2018

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# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

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

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

## Executive summary

### Introduction and background

This is the first time the Mental Welfare Commission has visited community hospitals to look at the care and treatment of people with dementia. This report gives a picture of the experience of patients and carers in these hospitals.

We visited 287 people with dementia, or who were being assessed for dementia, in 78 wards in 56 of the 89 community hospitals across Scotland. We did this because we know that a large proportion of patients in community hospitals have dementia.

Overall, around a quarter of patients had a diagnosis or were being assessed for dementia.

There has been a policy focus, in the three Scottish dementia strategies since 2010, on improving care for people with dementia in general hospitals.

Community hospitals vary considerably in scale, and in terms of the services they provide. They are small local hospitals providing a range of services close to their local community.

### The visits

We visited wards between June and September 2017 and met every patient who was able and willing to talk to us. We spoke with staff, and reviewed case files and drug prescription sheets, including those of patients we had not been able to talk with. We also heard from 104 carers.

We saw patients in a range of urban and rural settings, and in a range of larger and smaller units, including those where local GPs manage beds, and where beds were managed by specialist clinicians, usually geriatricians.

Three fifths of patients we saw or reviewed were female, and about half were 85 or over.

Just over half had been in the community hospital for a month or longer, and 18% for more than three months. Only 22% had been in the hospital for 15 days or less.

### Summary of findings

#### Environment

We found that more work could be done to personalise ward environments, and to make them more dementia friendly and provide more dementia-friendly resources.

All the wards were clean, and almost all were in good decorative order. Most felt like a pleasant place to be. Although, five wards felt very or fairly unpleasant, and 16 felt clinical.

Many community hospitals are in old buildings, and there were particular challenges in a few, for example, lack of access to shower facilities. However, not all old wards provided a poor environment, and newly-built wards did not necessarily provide a good environment.

Only a third of wards had carried out a dementia-friendliness audit of the environment. Problems included poor signage, flooring which could increase the risk of falls, and lack

of contrasting colours for toilet seats and grab rails to assist people with dementia to recognise and use them.

Personalisation could be improved on more than half the wards and there was variation in provision of dementia-friendly resources. There were examples of simple and low cost good practice, but we were concerned that some wards had very little to make them dementia-friendly.

### **Carers' experiences**

We heard from 104 carers and relatives, and generally, they felt positive about their relative's care and felt welcome on the wards. They valued the fact that their relative was in a local hospital, with flexible visiting, and with an atmosphere which was more relaxed and welcoming than in a busy acute hospital.

We wanted to see if families and carers felt fully involved, as outlined in Equal Partners in Care (EPiC).<sup>1</sup> In the main they were kept well informed, but there was scope for them to be involved more proactively in decisions about care and treatment.

Only half had had a verbal or written introduction to the ward.

Informal communication with nursing staff was good but only a third reported being able to speak to a doctor. In some wards carers were invited to review meetings, but two in five were not. Only just over half were given feedback from the ward round.

The majority were satisfied with the arrangements for feedback but 14% felt dissatisfied at the lack of a regular, reliable flow of information.

Half of the carers felt they were able to help with activities like mealtimes and social activities at least sometimes, but one in five reported never being able to do so.

One in five carers felt their relative's skills were not being maintained and two in five felt this was partial.

There was scope for carers to be given more information about supports they could access for themselves. Only 17% had been signposted to support by ward staff.

### **Care planning**

Very few patients had been admitted to hospital for care and treatment relating to dementia. Almost all had had a fall, or had a physical illness.

We saw that care planning focused very heavily on physical health care issues, and that physical health care needs were being well met. There was very good input from occupational therapy (OT) and physiotherapy services, focusing on rehabilitation. There seemed to be good input from geriatricians, who manage beds in some hospitals, but also provide medical input in some other hospitals.

However, in about half of care plans there was a lack of person-centred focus.

In three fifths of cases life story information was recorded, and in half of these we felt that information was being gathered well, but in a fifth of cases we saw no information.

<sup>1</sup> <http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx>

Care plans recorded physical health care interventions well, but there was a lack of care planning for care and support focusing on the patient's dementia.

Few care plans had information about a patient's abilities and skills, and few detailed how a patient was to be supported with personal care, and encouraged to maintain their skills and independence as much as possible.

We saw evidence of care planning for stressed/distressed behaviour in only a few cases (16%), often associated with good input from specialist mental health services.

Of the 57 cases where we felt a care plan for stressed/distressed behaviour should be in place but was not, half were being prescribed medication to be given 'as required' for agitation. We would have hoped also to see a care plan which sets out other interventions to minimise a patient's stress and agitation.

### **Medication prescription and review**

We recorded information about this for 85% of patients, of whom just over half were prescribed psychotropic medication.

Most patients who are prescribed psychotropic medication are having reviews of their continuing need for this. In about a third of cases, the review was in consultation with a psychiatrist or community psychiatric nurse.

For 43 people prescribed more than one psychotropic medication, there was evidence that medications were being reviewed in consultation with a pharmacist in just over a third.

A quarter of the people whose care we looked at were prescribed medication 'if required' for agitation. We were disappointed that more than half did not have a care plan for the use of this medication.

### **Rights**

Three quarters of patients had a certificate of incapacity in place, in most cases with a treatment plan. This was an improvement since our visits in 2010 to people with dementia in general hospitals. In 27 cases without a certificate (9%), Commission visitors thought that one was probably necessary.

In a very few cases we felt there were possible issues of unlawful detention, and in one case the patient was detained under mental health legislation after our visit. In all these 14 cases, a care plan for responding to stressed/distressed behaviour would have been appropriate but was not in place.

In five hospitals electronic location devices were being used.

When we discussed issues with staff in wards, we felt that staff often were not familiar with incapacity and mental health legislation.

In a quarter of cases restraint was being used, usually bed rails. In most cases there was an appropriate risk assessment, and we saw some risk assessments which clearly identified that the use of bed rails was not appropriate. However, in some files there was no information about a specific assessment, and in a few hospitals files would simply record that bed rails were in place 'as per hospital policy'. In one case, bed rails were in place despite an assessment that they were not appropriate.

In a third of cases where restraint was being used there was little or no evidence of regular reviews.

A third of patients we saw had previously granted powers of attorney and in a very few cases a guardianship order was in place, or was being applied for. When we examined patients' files, we found that in a few cases the specific powers were not recorded in care files, but contact details of welfare proxies were recorded and readily available to staff in most cases. Files showed that welfare proxies were being consulted appropriately about treatment decisions.

### **Activities**

It is important that meaningful and stimulating activities can be offered, particularly as so many people with dementia are spending considerable lengths of time in hospital. This can promote rehabilitation and recovery, and assist in reducing stressed and distressed behaviour. Without intense input patients can quickly lose existing skills, which can ultimately lead to them being unable to return to their previous accommodation.

Wards had good input from OT and physiotherapy, with a strong focus on therapeutic rehabilitation activity, helping patients regain mobility and independence following falls or episodes of physical ill health.

However, the overall picture was of very limited activity provision and, in more than half the wards, provision was limited or very poor.

In only two in five wards staff felt that patients who were physically mobile had sufficient opportunities to get out.

While we saw examples of good practice, we feel that more can be done to develop activity provision, and that community hospitals, which are almost all based in local communities, have opportunities to develop links with communities to enhance activity provision.

### **Discharge and delayed discharge**

In about half of cases patients were not ready for discharge.

In a few cases (9%) guardianship applications were in progress, and a quarter of patients required a residential placement. We saw that appropriate consideration was given to discharge home in most cases.

A fifth of patients needed arrangements for the provision of home care support. A quarter of these were awaiting funding, but in about three quarters of these cases delays were caused by the need to organise support. Often the patient had been receiving support at home before their admission to hospital, but the package of support was automatically cancelled after a short period of hospital admission.

### **How people feel about their stay**

Almost three quarters of the 134 patients who were able to comment either fully or in a limited way on their treatment were positive, and another one in four were very positive about it.

A number of patients told us about the quality of interactions with staff, often describing staff as kind, warm, caring and helpful. Most said staff were available to talk to and 99% felt safe on the ward.

Almost all patients felt they had enough privacy, although two people felt uncomfortable in a dormitory because of the lack of privacy. Five patients felt that it was boring in the ward.

Three fifths of patients had either not heard of advocacy, or were not sure. Only three patients told us they had an advocate, and two had been offered advocacy support but did not want it.

The Commission's recent Right to Advocacy report<sup>2</sup> recommended that strategic plans are developed based on a local needs assessment, and information about unmet need and gaps in local provision, and that they should address barriers people may be experiencing accessing advocacy support.

### Staffing

Three quarters of the wards had dementia champions on the ward team and a further 15% had access to a dementia champion based elsewhere. Wards commented positively about their impact. We saw clear benefits where staff who have trained as dementia champions are providing advice and support to other staff and to carers, developing good practice, and improving access to a range of resources for patients and carers.

Almost three quarters of the wards we visited had access to an Alzheimer Scotland dementia nurse consultant.

The levels of specialist training within the nursing team varied considerably. Two thirds had staff trained in identifying delirium, and half the hospitals had staff trained in the Adults with Incapacity Act.

Two fifths of the wards had no-one with training in the Newcastle model or other similar models for managing stress and distress. There was a lack of clarity about the different levels of knowledge and skills required by staff at the different Promoting Excellence dementia skills and knowledge framework<sup>3</sup> levels.

Access to psychiatry was available, mainly on a referral basis. However psychiatrists only attended multi-disciplinary team (MDT) meetings in one in three wards, usually on individual request.

Pharmacy input varied considerably. 82% of wards had access but only 69% said input from a pharmacist was regular rather than by referral; pharmacy attended MDT

<sup>2</sup> The Mental Welfare Commission (March 2018) *The Right to Advocacy - A review of how local authorities and NHS Boards are discharging their responsibilities under the Mental Health (Care and Treatment) (Scotland) Act 2003*

<sup>3</sup> Scottish Government, 2011, *Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers*  
<http://www.gov.scot/Resource/Doc/350174/0117211.pdf>.



meetings, either on a regular or invitation basis, in just 37% of wards. 15% of wards told us they did not have access to pharmacy input to the ward, even on a referral basis.

None of the wards we visited had regular input from psychology. 69% (49) were able to access this by referral, however, there seemed to be a lack of awareness amongst staff of the value of psychology to patients with dementia.

OT was an integral part of the multi-disciplinary team in most wards, and physiotherapy, dietetics and speech and language therapy were available to all wards on either a regular or referral basis. Social work input was available in all wards.

Access to a liaison service that specialises in the diagnosis and management of dementia varies considerably. Some wards have to go through the GP or consultant who can make a referral to the local mental health team, whilst others can make a referral directly. A few wards have regular input from a liaison nurse or community psychiatric nurse.

## Recommendations

Managers of community hospital wards should review this report with staff, patients and carers to consider aspects of their current practice which can be improved.

All Integrated Joint Boards should ensure that:

1. Wards use a dementia design audit tool every two years, and take appropriate actions to make ward environments as dementia-friendly as possible.
2. Staff use the Equal Partners in Care (EPiC)<sup>4</sup> framework, and encourage and enable carers to be involved in their relative's care and to work in partnership with staff, and that carers are given appropriate information as soon as possible after admission.
3. Staff use care planning systems which include a focus on supporting patients' needs in relation to their dementia. These should be based on personal life story information.
4. Medication should be used as a last, not first, resort in the management of stressed and distressed behaviours:
  - There should be a specific care plan detailing the non-pharmacological interventions to be used, informed by input from specialist psychiatric services (dementia nurse consultants, liaison nurses or psychiatrists) when required.
  - When a patient is prescribed medication 'if required' for agitation, there should be a clear care plan detailing when and how the medication should be used, and this should be regularly evaluated and reviewed.
  - People with dementia on multiple psychotropic medications should be prioritised for multi-disciplinary review, including pharmacy, to ensure that continued use is appropriate.
5. Where the use of electronic location devices is considered, there are protocols, including individual risk assessments and consultation with relatives/carers and attorneys and guardians; which should follow the Commission's good practice guidance, *Decisions about technology*.
6. Whenever the use of any form of restraint (for example bedrails) is being considered, staff complete an appropriate risk assessment, the need for restraint is kept under review, and the principles in the Commission's good practice guidance, *Rights, risks and limits to freedom*, are applied.
7. The service plan for each community hospital includes a focus on developing activity provision, and on encouraging input from local communities, in wards.
8. Staff provide patients with information about the reasons for being in hospital, and about their treatment, as often as is necessary, and that information given verbally is supplemented by information in other formats.

<sup>4</sup> <http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx>

9. Staff are proactive in helping patients access independent advocacy services and any barriers to access are addressed.
10. Health service managers give priority to ensuring:
  - that all non-clinical staff attain the knowledge and skills at the Informed level of the Promoting Excellence framework (see Appendix 2).
  - that all clinical staff attain the knowledge and skills at the Skilled level of Promoting Excellence using the NES national 'Dementia Skilled - Improving Practice Resource' (see Appendix 2).
  - that all wards in community hospitals are able to access support from staff at the Enhanced level, including dementia champions, and from staff operating at the Expertise level of Promoting Excellence.
  - that clinical staff have appropriate training on the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.
11. There is appropriate and timely input available from specialist dementia services and other specialisms, such as pharmacy, into community hospitals.
12. Local arrangements for cancelling home support packages when a patient is admitted to hospital are reviewed, with reference to the patient's likely duration of stay; and should consider developing flexible arrangements for restarting a package of care to enable patients to be discharged home quickly when they are ready to return home.

## Part 1 – Introduction and background

### Introduction

This report details what we found when we visited 78 wards in 56 community hospitals across Scotland, to look at the care and treatment of people with dementia when they are admitted to a community hospital. The report contains recommendations we have made about how community hospitals could improve the care provided, and highlights good practice we found on the visits.

### Why we carried out these visits

#### Background

Currently an estimated 90,000 people have dementia in Scotland, and in 2014 there were an estimated 16,712 individuals newly diagnosed with dementia. By 2020, this number is estimated to increase by 17% to 19,473<sup>5</sup>. As the population in Scotland ages and the number of people diagnosed with dementia increases, this will be reflected in an increasing use of hospital care by people with dementia. We know that up to a quarter of hospital beds are occupied by people with dementia who are over 65, and that people with dementia generally stay longer in hospital<sup>6</sup>.

The Commission regularly visits hospitals providing specialist care and treatment for people with dementia. We carry out local visits to look at the experiences of people receiving treatment in these wards, and we publish these local visit reports on our website. We also undertake themed visits each year. A themed visit is when we visit people in similar services, across a short period of time, with key questions for patients, staff and visitors.

Over the past 10 years we have undertaken a number of themed visits to look at the mental health care and treatment older people are receiving in different hospital settings:

- In 2007 we published *Older and wiser*<sup>7</sup>, about hospital wards providing continuing care for people with dementia. It identified the need for more consistent approaches to assessing needs, and to collecting life history information. It also said that the environment in a number of wards could be improved.
- In June 2010 we published *Where do I go from here?*<sup>8</sup>, a report on visits to mental health admission wards for older people. Actions needed focussed on several areas, including person-centred care planning, the environment, the assessment of capacity to consent to treatment, and advocacy support.

<sup>5</sup> Scottish Government, *Estimated and Projected Diagnosis Rates for Dementia in Scotland 2014-2020* (Edinburgh, 2016), <http://www.gov.scot/Publications/2016/12/9363/0>

<sup>6</sup> Health Improvement Scotland, *Focus on Dementia, Supporting improvements for people with dementia in acute care*, June 2016, <http://ihub.scot/media/1094/2016001-fod-acute-case-study-report-web.pdf>

<sup>7</sup> The Mental Welfare Commission for Scotland (2007) *Older and Wiser* <http://www.mwcscot.org.uk/media/53251/Older%20and%20Wiser%202007.pdf>

<sup>8</sup> The Mental Welfare Commission for Scotland (2010) *Where do I go from here?* <http://www.mwcscot.org.uk/media/53275/Where%20do%20I%20go%20from%20here%202010.pdf>

- In March 2011 we published *Dementia: decisions for dignity*<sup>9</sup>, a report on visits to people with dementia in general hospitals. We reported on a number of positive findings, and made recommendations around avoiding unnecessary moves between wards, assessing and reviewing capacity to consent to treatment, reviewing the prescription and administration of specific medications, training staff on relevant legislation, and dementia-friendly environments.
- In 2014 we published *Dignity and respect: dementia continuing care visits*<sup>10</sup>, about NHS wards providing longer term care for people with dementia. Our recommendations addressed medication and management of stressed/distressed behaviours, care planning and activities, multi-disciplinary input in wards, staff training, and the environment in many wards.
- In October 2015 we published *Making progress: older adult functional assessment wards*<sup>11</sup> about wards providing acute assessment for older people with functional mental illness, as opposed to dementia. A large majority of the wards regularly had patients with dementia, and we highlighted several issues about care and treatment for people with dementia.

This themed visit was arranged because we have not previously looked at how people with dementia are cared for in the non-specialist environment of a community hospital.

## Policy context

Scotland's first dementia strategy was published in 2010<sup>12</sup>. This said clearly that dementia was a national priority, and set out work to take forward to improve support, care and treatment for people with dementia and families and carers. It identified five key challenges and focussed on action to support improvements, particularly support after diagnosis and the response to dementia in health and social care. It said that it was important, when someone was in a general hospital with physical health problems that "staff in hospital plan for and provide care and treatment that takes account of the person's dementia." (Para 63)

The second dementia strategy covered the period from 2013 to 2016<sup>13</sup>. It highlighted progress being made, with improving diagnosis rates, Alzheimer Scotland nurse consultants appointed to health boards across Scotland, and 300 people trained as dementia champions by March 2013. There are now over 800 trained dementia champions. Although most of these will be acute general hospital staff, later cohorts included community hospital staff. The second strategy had 17 commitments, and spoke about the importance of developing post diagnostic support, of better integrated care

<sup>9</sup> The Mental Welfare Commission for Scotland (2011) *Decisions for Dignity* <http://www.mwcscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf>

<sup>10</sup> The Mental Welfare Commission for Scotland (2014) *Dignity and Respect – our visits to dementia continuing care wards* [http://www.mwcscot.org.uk/media/191892/dignity\\_and\\_respect\\_-\\_final\\_approved.pdf](http://www.mwcscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf)

<sup>11</sup> The Mental Welfare Commission for Scotland (2015) *Making Progress; older adult functional assessment wards* [http://www.mwcscot.org.uk/media/241555/making\\_progress\\_older\\_adult\\_functional\\_assessment\\_wards.pdf](http://www.mwcscot.org.uk/media/241555/making_progress_older_adult_functional_assessment_wards.pdf)

<sup>12</sup> Scottish Government *Scotland's National Dementia Strategy* (Edinburgh, 2010) <http://www.gov.scot/Publications/2010/09/10151751/0>

<sup>13</sup> Scottish Government *Scotland's National Dementia Strategy: 2013-16* (Edinburgh, 2013) <http://www.gov.scot/Resource/0042/00423472.pdf>

and support, of continuing to improve staff skills and knowledge, and of implementing an action plan for care in hospitals.

The third dementia strategy was published in June 2017.<sup>14</sup> This strategy maintains the focus on consistent high quality post diagnostic support, and improving care in hospitals and care homes. There are 21 commitments, and the strategy talks about people being able to live well and safely at home, having support from diagnosis to the end of life, having good care in all settings, and receiving personalised care and treatment in all NHS settings, whether in general hospitals or specialist NHS care.

In addition to the three national strategies, covering the period from 2010 to 2020, a lot of other work has been progressed nationally, to support improvements in dementia care. The Standards of Care for Dementia were published in 2011<sup>15</sup>, underpinned by the Promoting Excellence knowledge and skills framework<sup>16</sup> and the Charter of Rights for People with Dementia and their Carers<sup>17</sup>. In 2015, Healthcare Improvement Scotland published the Care of Older People in Hospital Standards, which include a standard on dementia care<sup>18</sup>.

Particularly relevant to this themed visit, commitment 10 in the second dementia strategy said “we will develop and deliver a three year National Action Plan to improve care in acute general hospitals.” A 10 point national framework, 10 Dementia Care Actions in Hospital, was created, with all NHS boards committed to continuous improvement across the 10 care actions, to ensure that care and treatment people with dementia receive in hospital is safe, co-ordinated, and person centred.

## About community hospitals

### What are community hospitals?

Community hospitals have had an important role in the provision of healthcare in Scotland for many years, and in some areas a community hospital will have been part of a local health care system for over a hundred years. Many community hospitals predate the NHS, and were established by local benefactors, or were built with local donations.

<sup>14</sup> Scottish Government *Scotland's National Dementia Strategy 2017-2020* (Edinburgh, 2017)  
<http://www.gov.scot/Resource/0052/00521773.pdf>

<sup>15</sup> Scottish Government *Standards of Care for Dementia in Scotland* (Edinburgh, 2011)  
<http://www.gov.scot/resource/doc/350188/0117212.pdf>

<sup>16</sup> Scottish Government, 2011, *Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers*  
<http://www.gov.scot/Resource/Doc/350174/0117211.pdf>. This learning framework was developed by NHS Education for Scotland and the Scottish Social Services Council for all health and social care staff. It has four practice levels: Dementia informed (baseline knowledge and skills required by all staff working in health and social service settings); Dementia skilled (all staff with direct and/or substantial contact with people with dementia); Dementia enhanced (staff who have more regular and intense contact with people with dementia, provide specific interventions and/or direct/manage care and services) and Dementia expertise (staff who by virtue of their role and practice setting play an expert specialist role in the care, treatment and support of people with dementia).

<sup>17</sup> [https://www.alzscot.org/assets/0000/2678/Charter\\_of\\_Rights.pdf](https://www.alzscot.org/assets/0000/2678/Charter_of_Rights.pdf)

<sup>18</sup> Healthcare Improvement Scotland (2015) *Care of Older People in Hospital Standards*  
[http://www.healthcareimprovementscotland.org/our\\_work/person-centred\\_care/resources/opah\\_standards.aspx](http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/opah_standards.aspx)

There is no agreed definition of a community hospital, and they vary considerably, many of them as they have adapted to the needs of their local populations over the years. The most commonly used definition is Ritchie's:

"A local hospital or unit, providing an appropriate range and format of accessible health care facilities and resources. These will include in-patients, out-patients, diagnostics, day care, primary care and outreach services for patients provided by multidisciplinary teams"<sup>19</sup>.

While community hospitals vary considerably in terms of the services they provide, they are fundamentally small local hospitals providing a range of services to their local community, offering these services close to people's homes and families.

### Community hospital policy

A key part of national health policy is to shift the balance of care from large institutions, and deliver care where possible in community settings, expanding primary care-led services. The Scottish Government has set out a route map for their 2020 vision for health care in Scotland, which emphasises this<sup>20</sup>. Community hospitals are seen as an important part of this approach, providing care closer to home after an admission to larger acute hospitals, or avoiding an unnecessary admission to an acute hospital, which for many people will be some distance from where they live, by providing short stay treatments.

An initial policy document, *Developing Community Hospitals*, was published in 2006<sup>21</sup>. This set out a vision for community hospitals as part of an extended primary care service, providing health services closer to communities. The Community Hospital Strategy Refresh in 2012<sup>22</sup> outlined plans for the future development of community hospitals, seeing them as sitting at the heart of expanded and integrated community services. This strategy refresh had nine actions for health boards to progress, to make sure that each community hospital had a clear plan for developing the services available for local communities, and that the learning and training needs of staff in the hospitals were addressed. The health board actions include a specific action to address staff training needs, particularly around the care of older people with dementia, recognising that the role of community hospitals in providing care for this group of people will increase.

Current community hospital policy therefore recognises that these hospitals will provide care and treatment for increasing numbers of people with dementia, often with other long term health conditions, and often to provide rehabilitation after treatment for a physical health problem in a large acute hospital. The policy acknowledges that community hospitals provide services closer to home, and often in a more relaxed atmosphere than in a busy acute hospital. It says they should have a key role in the future providing care and treatment directly in the communities where they are based,

<sup>19</sup> Ritchie, L (1996) *Community Hospitals in Scotland –Promoting Progress*, University of Aberdeen

<sup>20</sup> <http://www.gov.scot/Resource/0042/00423188.pdf>

<sup>21</sup> Scottish Executive *Developing Community Hospitals: A strategy for Scotland* (Edinburgh, 2006) <http://www.gov.scot/Resource/Doc/161360/0043790.pdf>

<sup>22</sup> The Scottish Government *Community Hospital Strategy Refresh* (Edinburgh, 2012) <http://www.gov.scot/Resource/0039/00391837.pdf>



and that health boards should be looking to develop services provided in these hospitals.

### **How we carried out the visits**

We developed interview schedules for patients, carers, and staff, and also a brief audit tool for the physical environment in wards. To help us decide what questions we wanted to ask, the Carer Engagement and Participation Officer in the Commission consulted with a range of individuals and groups to gather information about issues they felt would be relevant for us to focus on in visits. We thank people for the time they took to help us.

We carried out two pilot visits using these schedules, to Ward 3 at Stirling Community Hospital, and to Kilsyth Victoria Cottage Hospital. We would like to thank staff there for their co-operation in allowing us to do this.

We visited wards between June and September 2017. Letters were sent out to let hospitals know we were coming, and to give details of the information we would want to collect on the day of our visit. This included information about the number of beds occupied and vacant at the time of our visit, and specific information about the patients who had been diagnosed with dementia, or were being assessed. With the letters arranging visits we also sent letters to be given to patients, to tell them about the visit, and posters to be displayed in the ward. There was an information leaflet for relatives/carers, and copies of a questionnaire for carers. We wanted to hear the views of as many carers as possible, so carers were offered the option of meeting Commission visitors on the day of the visit, contacting us by telephone to give us their views, or completing the questionnaire themselves and sending this to us.

On the day of our visit we met every patient in a ward who had a diagnosis of dementia, or was being assessed, and who was able and willing to talk to us. We met staff, and all relatives who wanted to speak to us. We also reviewed the case files and drug prescription sheets for all the patients with a dementia diagnosis, or in the process of being assessed, in the ward. This included the patients we had not been able to talk with.

### **Where we visited**

The common feature of community hospitals is their variability. There is no agreed definition of a community hospital, and different hospitals can provide a widely different range of healthcare services and in-patient beds. In-patient beds in community hospitals can be managed by local GPs, or can be managed by other clinicians, normally geriatricians.

We wrote to the 14 regional health boards in Scotland asking for details about the hospitals they classed as community hospitals in their areas. We also asked for information about the wards and bed numbers in these hospitals. We used this information to establish which wards would be visited in this themed visit programme.

Two of the island boards, NHS Shetland and NHS Orkney, do not have any community hospitals, with the hospitals there categorised as rural general hospitals. From the information we got back from the other 12 boards, we saw that 89 hospitals were defined as community hospitals. These hospitals vary in greatly in size, with St Brendan's Hospital on the Isle of Barra for example having five beds, and the Royal



Victoria Hospital in Dundee, at the time of our visit, having six wards with 97 beds. Most of the hospitals we visited, though, had only one ward with in-patient beds.

We visited 56 of the 89 hospitals across Scotland, seeing patients in 78 different wards. A full list of where we visited can be found in Appendix 1. We went to every health board area with community hospitals, apart from NHS Western Isles, which only has two small community hospitals. We could not visit all the community hospitals across Scotland, but we selected hospitals to visit, to make sure that we were seeing patients in a range of urban and rural settings, and in every health board apart from NHS Western Isles.

We received data about bed occupancy and the number of patients with dementia from 65 wards. Although this is incomplete data, and reflects only the position on the day the return was filled in by each ward, it indicates that around a quarter (274 patients out of 1,065 occupied beds) had a diagnosis or were being assessed for dementia.

We wanted to look at the care and treatment provided to people with dementia in small single ward units, and in larger hospitals. We also wanted to ensure we visited hospitals where medical input was provided by local GPs who were managing beds, and hospitals where beds were managed by specialist clinicians, usually geriatricians. We did not visit any ward in a community hospital where bed provision was managed by a consultant psychiatrist, as these wards would be part of specialist NHS mental health services, and would be included in our routine local visit programme.

We visited hospitals in 11 health board areas on this visit. NHS Grampian and NHS Highland, which both cover extensive rural areas, each have 17 community hospitals, so we visited more hospitals in these areas. The table below sets out how many hospitals and wards we visited in each health board:

NHS Boards	Hospitals	Wards
Ayrshire and Arran	5	8
Borders	4	4
Dumfries and Galloway	5	8
Fife	3	6
Forth Valley	2	4
Grampian	9	12
Greater Glasgow and Clyde	1	2
Highland	11	12
Lanarkshire	4	4
Lothian	4	7
Tayside	8	11
Total	56	78

## Who we visited

In our visits to 78 wards we looked at the care of 287 patients. Of these patients about half (48%, 138) were able to engage in an interview, and answer questions to some extent. We reviewed the records, including medication charts, for all 287 patients.

The majority of patients we saw or reviewed were female (61%, 176). About half (51%, 146) were 85 or over, and just under half (45%, 130) were aged between 65 and 84. A very few (4) were between 45 and 64.

None of the patients were formally detained under mental health legislation when we visited.

We asked for information about where patients had been admitted to community hospitals from. A majority of patients had been admitted from an acute or a district general hospital (62%, 177). A minority (26%, 74) had been admitted from their home, while a very few (1%, 4) had been admitted from a care home. In a few cases (11%, 32) it was not clear where the patient had been admitted from.

We gathered information about the primary reason patients had been admitted to hospital. In just under half of cases (125, 44%) it was recorded that admission followed a fall at home, with a number of other records indicating that admissions were linked to a fall and other physical health problems. There has been a National Falls programme in place in Scotland since 2010, and the Scottish Government published its falls prevention strategy in October 2014<sup>23</sup>. The information we collected on these visits suggests that falls are commonly associated with admissions to hospital for people with dementia, and underlines the relevance of the national falls prevention work.

We looked at how long each patient had been in the community hospitals when we visited (Table 1). In a very few cases the exact length of stay was unclear (3%, 9). The majority of patients (55%, 157) had been in the hospitals for a month or longer, and a significant number (18%, 52) had been in hospital for more than three months, while only a minority (22%, 65) were in the hospital for 15 days or less. We were interested in length of stay because it is particularly important that people have appropriate care relating to their dementia where they are in hospital for a long period, as opposed to a very short stay.

**Table 1. Patients' length of stay in community hospital at the time of our visit**

Length of time in community hospital	Number	%
More than 90 days	52	18%
46-90 days	69	24%
31-45 days	36	13%
16-30 days	56	20%
6-15 days	47	16%
0-5 days	18	6%
Not clear	9	3%
Total	287	100%

<sup>23</sup> The Scottish Government *The Prevention and Management of Falls in the Community. A framework for action for Scotland 2014/2016* (Edinburgh, 2014)  
<http://www.gov.scot/Resource/0045/00459959.pdf>

## Follow up

In a third of cases (31%) we took follow up action on the day of our visit, or after the visit, as a result of our findings. We did this on 90 occasions. Most issues were resolved on the day of the visit, and usually involved giving staff advice, or clarifying an issue for staff, for a patient, or for a relative or carer. We also wrote formally to managers or doctors on four occasions, in relation to more important matters.

Following visits we sent a brief report to unit managers highlighting any concerns or good practice we wanted to identify.

## Part 2 – Findings

### Environment

#### The physical environment

##### What we expect to find

We expect to find not only that wards are clean, well-maintained, comfortable and free from unacceptable noise and odour, but also, given the high proportion of patients with dementia, that the environment is dementia friendly. The disabling impact of dementia is strongly related to environment. The wellbeing of people with dementia is affected, for example, by how easy it is to find and recognise important places such as toilets and bedrooms, whether flooring is appropriate, whether key features such as grab rails and toilet seats stand out, and whether there are stimulating items to look at or handle.

##### What we found

All the wards were clean, and almost all were in good decorative order. However, we found that much more could be done to make many of the wards dementia friendly.

#### The general environment

Two wards had only dormitories, but most wards (80%, 56)<sup>24</sup> had a mixture of single rooms and dormitories or bays, with 17% (12) further wards having only single rooms. In general there was limited privacy, with many patients accommodated in shared bays or dormitories, with privacy provided only by curtains and screens. Single rooms could be locked from inside in only 20 wards, and only 26 had closable observation windows (or no windows in the door).

Three quarters of the wards (77%, 54) provided a room, other than bedrooms, where patients could meet visitors, and where this was not the case in most wards we were told about other options such as using a room elsewhere in the hospital, or the day or dining room.

Most of the wards were calm and quiet, although 10% (7) had some issues with noise, which can be especially challenging for people with dementia.

*Ward is quite noisy as two cramped adjoining bays (including 10 dorm beds) for all 12 patients, with no doors between and TVs/ radios on and people chatting in different areas. The only partitions throughout are curtains, so noise travels. Also most patients remain in their beds/in their bed area and do not use patient lounge to watch TV. (MWC visitor)*

Maintenance was an issue in 23% (16) of wards. In some cases this related to old buildings which are no longer fit for purpose, and in others it was smaller issues such as flooring replacement or repairs, some of which were already in hand.

<sup>24</sup> We obtained 70 environment returns; a small number covered findings for a group of one or more wards in a hospital/unit.

Our visitors rated 70% (49) of the wards as feeling like a very or fairly pleasant place to be. However, five wards felt very or fairly unpleasant, and our visitors found that 16 felt clinical.

*Very few examples of stimulating items. Very few pictures. Very clinical (clean and modern) environment. (MWC visitor)*

*Still has a clinical feel. Senior charge nurse advises infection control are reluctant to allow decoration. (MWC visitor)*

It was notable that wards in the same hospital were sometimes very different:

*When compared to [ward X], [ward Y] is a more clinical, sterile ward. Very little personalisation with furnishings and fittings. Not the same attention to detail that is visible in [ward X]. (MWC visitor)*

Many community hospitals are in old buildings, and the structure and layout of outdated facilities brought particular challenges.

*Not fit for purpose. No en-suite rooms - both bathrooms have to be accessed via a dormitory and may involve male patients traversing a female dormitory to reach it. (MWC visitor)*

*Ward is clearly not fit for purpose and in need of major renovation / complete rebuild. PQI (Patient Experience Quality Indicators) inspection visits in 2014 & 2017 have highlighted same [...]. There are no showers for the 12 patients. No en-suite facilities. [...] Bath has lifting chair but not full body hoist, so many patients unable to bathe. [...] As there are no showers in the building, majority of patients receive bed baths. Two of the patients I saw were doubly incontinent on a daily basis. Nursing staff told me this is managed by bed baths in their dorm beds. [...] we had significant concerns re lack of dignity and privacy, as well as issues of hygiene and management of skin integrity due to lack of shower facilities. (MWC visitor)*

*The day room looks like a store room for chairs, is small, echoes, impersonal (no pictures) and is used for storage so is completely unsuitable. The floor is not level. The corridor and layout of rooms is confusing. The main 3 bed room is effectively a corridor. Privacy is difficult to maintain. The two bed room used for two men with dementia opens onto road and although door is alarmed this is far from ideal. Signage is in place for toilets but doors are all left open because they are old and heavy. Plan is for eventual ward relocation but nothing has started. (MWC visitor)*

However, not all old wards provided a poor environment, and newly-built wards did not necessarily provide a good environment:

*Ward is an old ward in an old building (a new build is planned but may be a number of years away). Given the constraints of the building the ward feels pleasant and homely with a very large communal area, different types of seating suitable for patients with different needs. (MWC visitor)*

*The ward is located within purpose built facility opened in 2010. There are 3 day rooms, none of which were occupied during the visit. They are bright rooms but*

*starkly decorated and furnished and not particularly welcoming. The flooring is not dementia friendly and has been patched with different colour/texture flooring which is not recommended for dementia patients. This has been recognised and will be amended at next available opportunity for upgrading. (MWC visitor)*

### Personalisation of the environment

We asked our visiting practitioners to rate the personalisation of each ward. It is important for people with dementia that they are able to recognise and feel comfortable in their own bed or room, and having familiar items and pictures can help this. Fewer than half (44%, 31 wards) were rated satisfactory or very good.

*Patients' bed spaces are not personalised other than named on boards. There are no dementia specific items such as rummage boxes and nothing to orientate patients to their specific bed areas. (MWC visitor)*

In some places we were told that patients were generally in the ward for short stays, and that this limited personalisation. However, we believe that it is still possible to personalise patients' bedspaces even for short stays. More than half the patients we visited (55%) had been in the hospital for a month or more.

*Patients here sometimes for 257 days with no personalisation. Otherwise this is a modern well maintained if clinical ward. (MWC visitor)*

There were example of good practice from wards which had succeeded at personalising the environment, often in ways which were simple and low cost:

*Ward has features pertaining to local area. In patients' own rooms patients can bring personal belongings such as cuddly toys, crochet blankets to use while stays. Cards and photos. (MWC visitor)*

*Patients can have personal items by beds in spite of often short stay. (MWC visitor)*

### Dementia friendliness

We found that while physical disabled access was good in most wards, with wide doors and corridors, ramps, lifts and disabled toilet facilities, the picture was less good for dementia friendliness.

We asked whether a specialist environmental audit tool for dementia had been used in each ward. There are a number of resources available, including a self-audit tool and accreditation from the Dementia Services Development Centre<sup>25</sup>, and the Kings Fund Environmental Design Audit Tools<sup>26</sup>. The Dementia standards<sup>27</sup> state that regular audit should take place. Only a third of wards (33%, 23) had carried out an audit. In most cases this was within the last two years. We have made a recommendation about this.

<sup>25</sup> Dementia Services Development Centre (2011) *Dementia Design Audit Tool 2011*  
<http://dementia.stir.ac.uk/design/accreditation>

<sup>26</sup> The King's Fund Environmental Assessment Tools <https://www.worcester.ac.uk/discover/kings-fund-environmental-assessment-tools.html> [accessed 16/01/2018]

<sup>27</sup> Scottish Government *Standards of Care for Dementia in Scotland* (Edinburgh, 2011)  
<http://www.gov.scot/resource/doc/350188/0117212.pdf>

There were a number of ways in which some of the ward environments were unhelpful to people with dementia. These included:

- Signage should be clear, well-lit, in a bold typeface and with a good contrast between text and background. This was the case for all signs in half the wards (54%, 38), but for only some of the signage in 41% (29) of the wards. In three wards (4%) no signs were up to this standard.
- Other signage, for example for bedrooms, quiet room, etc, was not adequate in 12 (17%) wards and only some of the signage was clear in a further 20 (29%) wards.
- Grab rails should be in a contrasting colour to assist people with dementia to recognise and use them. This was consistently the case in only just over half (56%, 39) of wards.
- Patterns, reflections and changes in flooring can cause difficulties for people with perceptual problems, and may cause them to fall. We identified no issues with the flooring in only a quarter of wards (24%, 17). Problems in the other wards included patterned flooring (20%, 14), reflective or slippery floor surfaces (23%, 16), stepped changes in floor finish (27%, 19) and changes in floor colour at thresholds (64%, 45). Some wards had more than one of these issues, and three wards had all of them.

### Toilets

While some people with dementia do experience continence problems, often apparent difficulties with continuance can be caused not by physical issues but by difficulty in finding and identifying the toilet. We would expect toilets to be clearly signed, easy to find and to have a contrasting toilet seat to aid identification. We found that 21% (15) of wards needed to improve signage for toilets. Signage may be unnecessary if the toilet itself is clearly visible, but this was often not the case. In about a third of wards it was not possible for some or all patients to see the toilet from their bed, and in 12 wards the toilet door was not adequately signed.

Fewer than half the wards (44%, 31) had contrasting toilet seats in all toilets, and 36% (25 wards) had no contrasting toilet seats.

### Quiet rooms

People with dementia may find busy environments confusing and disabling, and may need a quiet place to go if they are feeling anxious or confused. We were pleased to find that most wards provided this, but concerned that 19% (13) did not.

### Garden

There was easy access to a garden or green space in only 57% (40) of wards. The available outdoor space was dementia friendly, for example safe and secure, with clear and smooth pathways, and interesting and colourful items to look at, in only 40% (28) of wards.

*Good paths, lots of objects especially bird table and bird bath (very popular).*  
(MWC visitor)



While some wards were unable to provide access to a garden because of the constraints of the site, others had garden space, but patients with dementia were not able to make the most of it due to a range of factors, including physical access, staff time and poor layout and/or state of repair.

*Outdoor space slightly neglected but some colourful plants. But family need to take people out and accessibility via ramp appears awkward. (MWC visitor)*

Despite lacking a garden, some wards made good use of other outdoor facilities:

*There is no enclosed private garden space for ward 2 [...], however, there is a lot of accessible outdoor space on the site for patients who can go outside with assistance: small putting green and a community garden which has raised beds, fruit trees, polytunnel and beehives. This is funded by League of Friends and maintained by local community for the hospital & patients to enjoy (incl fruit & veg grown) (MWC visitor)*

### Other dementia-friendly resources

Overall, we saw a mixed picture of provision of dementia-friendly resources. We saw a number of examples of good practice, including simple approaches to making wards more dementia friendly, such as providing activity materials, rummage boxes, reminiscence boxes, reality orientation and items to fiddle with.

*This is a small 6 bed cottage hospital but it is pleasant and a lot of care and thought has gone into making environment & activities dementia friendly - esp in communal day room. The 'Friends of Edington hospital' have fundraised for an activity co-ordinator as well as equipment/ chairs etc. The activity co-ordinator has acquired a lot of arts & crafts supplies & there is evidence of patients' work on walls and around day room. There are also reminiscence books & objects and twiddle muffs (latter provided by local charity). (MWC visitor)*

*Pictures of local area, each patient has a board in their room with flower to highlight [to] staff patient has dementia. Dementia friendly clocks. Quiet and tranquillity helpful for some patients with confusion. (MWC visitor)*

*Welcoming, plenty of visitors around. Notice boards give visitors and patients good information on the ward, advocacy, carers' support, and dementia champion. Dementia friendly signage is reasonably good. Communal areas have orientation clocks at patient eye level in prominent areas. (MWC visitor)*

Some wards were in the process of improving:

*There are some rummage boxes but otherwise a clearly clinical area. They are in the process of carrying out a dementia specialist audit. On the day of the visit they had clocks and information boards for each room and communal area that will give information on time, date, day and weather. (MWC visitor)*

However, we were concerned that some wards had very little to make them dementia friendly.

*Nothing in place - this is a totally unsuitable environment for dementia care. (MWC visitor)*



*Posters on dementia awareness, no pictures/paintings. No books or games.  
sitting room large area with chairs against all 4 walls. (MWC visitor)*

## Carers' experiences

### What we expect to find

The role of the family carer for individuals with dementia is vital, especially where that person has lost capacity. We expect to find that family and carers are fully involved in the care and treatment of their relative, and that their unique knowledge of the individual is used to optimise and personalise the care given and to help the person with dementia to participate as fully as possible in decisions. We hope to see family welcomed onto wards and being encouraged to help with their relatives as partners in care.

### What we found

We heard from 104 carers during the course of our visits, covering 11 health boards and 47 different hospitals.

Of the 104 carers, the majority, 51% (53), were the patient's children with 30% (31) being a spouse. This might be expected as 60% of the patients were over 85.

It is a core principle of Equal Partners in Care (EPiC)<sup>28</sup>, the national framework for workforce learning and development related to unpaid carers, that carers are recognised and valued as equal partners in care. The Triangle of Care<sup>29</sup> also emphasises a therapeutic relationship between the person with dementia, staff member and carer that promotes safety, supports communication and sustains wellbeing. However, 28% (29) of carers reported they had had no introduction to the ward, 12% (12) could not remember and 52% (54) reported some form of introduction either verbal or written; for 9% (9) information was not clear.

*Just arrived, little info about ward, communication irregular. (Carer)*

*The staff nurse was very helpful on arrival. She asked me about mum and explained things to me. (Carer)*

### Involvement and information

We know it is very important for individuals with dementia to have familiar people around them. In our visits we found that 87% (90) of carers felt involved with their relative's care. 50% (52) felt fully involved and 37% (38) sometimes involved.

Only 5% (9) reported being dissatisfied with their level of involvement and the main reasons were having to seek out information rather than have a process for regular updates.

*Really don't have a complaint, but... I wish they would involve us more. (Carer)*

81% (84) reported always being able to speak to a nurse when they wanted to but only 29% (30) reported being able to speak to a doctor.

<sup>28</sup> <http://www.knowledge.scot.nhs.uk/home/portals-and-topics/equal-partners-in-care/about-equal-partners-in-care.aspx>

*I have never seen or been contacted by a doctor and have been given no feedback whatsoever by any doctors involved. (Carer)*

*Couldn't be any more helpful. [re nursing staff] (Carer)*

However, 39% (41) of people reported they were not invited to review meetings, with a further 16% (17) being unsure if they had been.

*I'm not aware of meetings happening. I visit most days. (Carer)*

*Only 1 meeting in 6 months to be informed he had to find a placement for his wife in a care home. (MWC visitor)*

In some hospitals we heard about good practice in involving carers in review meetings, for example, at Woodend Hospital, Grampian:

*The first review meeting I attended, the consultant, ward doctor and nurse attended - purpose of this meeting was to review my mum's medication. The need to adjust mum's medication and the possible effect of that was fully explained to me and my agreement sought for the changes. (Carer)*

The vast majority of people, 86% (89), were kept updated with progress while visiting and just 16% (17) were updated at meetings. 38% (39) were contacted by phone.

55% (57) of carers said they were given feedback from the ward round but this was always the case for just 25% (26), and the rest, 30% (31), said this happened sometimes. 19% (20) claimed never to have had any feedback. For the remaining 26% (27) it was not relevant (perhaps they were not the carer to receive feedback, or it was too early) or not clear.

The majority, 63% (65), were satisfied with the arrangements for feedback on their relative's ward, however 14% (15) felt dissatisfied. The main complaint around feedback and information, similar to the comments on involvement, was that many carers had to seek feedback rather than have a regular, reliable flow of information.

*The staff were all aware of my gran's care so no matter what member of staff you spoke with the information that was passed on was correct. (Carer)*

*All parties involved meet daily to decide on the best course of treatment. (Carer)*

The vast majority of carers, 81% (84), were aware of their relative's diagnosis of dementia, although six felt this was to a limited extent only, but 16% (17) were either unsure or did not know.

*Communication is problematic. She always finds out only by asking questions. Diagnosis of Alzheimer's was given 3rd hand. Podiatry has not been addressed. Medication changes are not communicated. (MWC visitor)*

We had heard during our consultations that losing possessions was a particular problem for some individuals with dementia. We found however that only 16% (17) of carers reported this as an issue with 12% (12) having experienced it more than once.

*Underwear found in other patient's locker, there are problems with others taking things, part of illness, Staff manage it well and always try to find things. (MWC visitor)*

We saw one very good example of how information was being shared with carers at Whitehills Health and Community Care Centre. As well as clearly displaying information about supports for carers, they had created a notice board with information about the 10 dementia care actions in hospitals developed as part of the second national dementia strategy. All the actions were listed, with information about what has been done and what is still planned to be done for each action.

## Visiting

Almost all the carers, 96% (100), reported feeling welcome on the wards either most or all of the time. No carers on our visits had been made to feel unwelcome on any of the wards.

Most people, 73% (76), could visit whenever they liked and all but one unit had flexible visiting hours. Although some said they did have protected mealtimes, family were also encouraged to assist their relative with eating and drinking if they wished to do so. All wards should have protected mealtimes in place as part of the Food, fluid and nutritional care standards<sup>30</sup>. This would not prevent families and carers assisting an individual during mealtimes. We would expect this to be in the care plan for nutritional care.

Private areas for visiting were always available for 57% (59) of visitors and sometimes for a further 15% (16). 15% (16) reported no privacy.

Only 46% (48) could always go outside with their relative and a further 20% (21) managed sometimes. Of the 26% (27) who reported never being able to go outside, virtually always this was due to the frailty of the individual.

*Excellent visiting arrangements. I feel like I can come whenever suits me, which benefits my dad because I can visit frequently. (Carer)*

A familiar face helping at mealtimes has been shown to improve eating in many people. Having relatives available to help with other activities often helps calm an individual with dementia who may be distressed and confused on an unfamiliar ward.

On our visits we found 50% (52) of carers felt they were able to help with activities like mealtimes and social activities at least sometimes, but 20% (21) reported never being able to do so.

*Nursing staff are happy for me to support my mum in any way, for example just keeping her company, helping to feed her when required, encouraging her to watch TV, help her to take part in games such as ludo, snakes and ladders, dominoes, word searches and colouring in. (Carer)*

*Able to assist with personal care and have dinner with him. Health Care Assistants help us with this. (Carer)*

The new Carers (Scotland)) Act 2016 will take effect on 1 April 2018 and it gives carers the right to be included in discharge plans. We found that 57% (59) of relatives felt

<sup>30</sup> Healthcare Improvement Scotland (2014) *Food, fluid and nutritional care standards*  
[http://www.healthcareimprovementscotland.org/our\\_work/patient\\_safety/improving\\_nutritional\\_care/nutritional\\_care\\_standards.aspx](http://www.healthcareimprovementscotland.org/our_work/patient_safety/improving_nutritional_care/nutritional_care_standards.aspx)

involved in discharge planning and 41% (43) of cared for individuals had a discharge plan in place. Seven relatives felt excluded from the discharge planning process.

*It would appear that social work are making these decisions for us without consulting us. (Carer)*

*We have been advised he is bed-blocking. I am at present gathering information re a placement. I am being left to do all the work re meetings, taking aunt to view possible homes etc. (Carer)*

Of the 39% (41) who were not aware of a discharge plan about a third (15) of their relatives had been in hospital less than a month.

### Care and treatment

The vast majority of carers expressed satisfaction about the care and treatment being provided to their relatives. 87% (90) stated they were either fairly or very satisfied, with only three slightly or very dissatisfied. These issues were around the individual being given food they didn't like and worries about managing at home with their relative after discharge.

*Staff always seem like they have all the time in the world for my dad. They treat him with respect and give him good care. (Carer)*

*Said she knows her mother at times can get stressed and may say things to staff - she feels staff deal with this patiently and calmly. She was not aware of this herself until she witnessed her mother being quite derogatory to a nurse on one visit - she was impressed with how the nurse dealt with this and she felt she had to apologise to the nurse for her mother's comments. (MWC visitor)*

We heard from some carers about a scheme used in some units as a way of letting staff know that the patient they are supporting has dementia. If a symbol is placed above the bed it signifies the patient has difficulties and visiting staff will know to seek advice from the nurses. It also preserves confidentiality for the patient. We heard about this working well in Stracathro Hospital, Tayside, but in another hospital a carer told us that the symbol was not displayed above their relative's bed. It should be noted, however, that there can be ethical issues about such schemes, in terms of possible stigmatisation of people identified in this way. Where the use of such an identifier is considered, this should, where possible, be discussed with the patient, and if the patient objects this should be respected.

### Carer support

Caring for someone with dementia can be exhausting and places enormous stress on families.

Providing access to support and advice for carers is important and ensuring that carers are supported and empowered to manage their caring role is a core principle of Equal Partners in Care principles.

However, only 17% (18) of carers on our visits were signposted to any support by ward staff. 20% (21) managed to find support from another source but 54% (56) said that no support had been offered.

*I am physically and mentally exhausted and would be grateful for any support either health or financially, no one seems interested in my plight. (Carer)*

Providing information on the ward and directly, from nursing staff signposting family to support for themselves, can make an enormous difference in allowing carers to carry on their role or make appropriate decisions about future care for their relatives.

### **Guardianship and power of attorney**

64% (67) of carers we heard from were welfare guardians or had welfare power of attorney in place.

67% (45) of these felt that their position was respected on the ward with 18% (12) feeling they were sometimes given their place. A few (4%, 3) however said their position was not respected at all.

*Care and treatment cannot be faulted but nurses do not seem to understand the need to consult with Power of Attorney. (Carer)*

*Doctors wanted to stop Warfarin. I said no and they did it anyway without my consent and this resulted in a clot in my husband's leg. After this incident a blood thinner was given again. This has caused additional pain and discomfort and it is injection into stomach. This was very distressing for the family. (Carer)*

*I hold Welfare Power of Attorney and the doctors do consult me, for example when my mum was not responding well to her medication the doctor suggested slight adjustments but did ask for my agreement. The staff do respect my role and are happy to take on board any suggestions or information I can give them about my mum seeing that my mum is unable to tell them myself. (Carer)*

### **Transfers**

One issue that we did not ask about but which was highlighted as a problem several times was the transfer to the community hospital from the referring unit.

14 people (13%) told us about unsatisfactory transfers.

Problems included a patient transferred with no clean clothes, short notice to the family and lack of planning for the transfer.

*My dad was transferred on a winter night windy and wet by taxi with just PS/housecoat and slippers with auxiliary who could hardly get him in or out of taxi because he was not good on feet. (Carer)*

## Care planning

### What we expect to find

A good care plan will have the individual patient at the heart of it. We expect that patients are supported to be as involved as possible in their care and treatment, and that care plans are person centred, are reviewed regularly, and have information about specific nursing interventions and care goals.

### What we found

Care plans are important, as they provide direction for the individualised care of the patient, and they make sure that care is focussed on the patient's specific needs, and that the patient gets the same care whichever staff are on duty in a ward.

The Royal College of Nursing (RCN) has identified five principles, known as the SPACE principles, which are designed to ensure people with dementia receive the best treatment in hospitals<sup>31</sup>. One of these key principles is that care plans should be person centred and individualised, based on an understanding of how dementia affects the individual patient. The Scottish national dementia strategies have also focussed on improving care in hospital settings, and making sure people with dementia experience dignified and person-centred care.

We examined the care plans for every person whose case we reviewed on visits. Commission practitioners were asked to consider whether plans were person centred and had information about care goals and about maintaining patients' skills. They looked at whether plans were informed by information about individual life histories and patient preferences and views. They also looked at how care plans addressed both physical health issues and chronic conditions, and any needs relating to dementia. We particularly focussed on whether there were care plans for intervening to reduce stressed/distressed behaviour, where this was appropriate, in line with the Dementia Standards<sup>32</sup>.

When we considered how person-centred care plans were, we felt that overall about half of plans had a person-centred focus. A minority (24%, 68) were well focussed on the needs of the individual patient, with information about treatment goals and the patient's skills and wishes, whilst 21% (61) had some person-centred details. This does mean though that in about half of care plans we felt that there was a lack of person-centred focus, in the way plans had been completed.

We looked at the availability of life history information in files, as care plans should be supported by the routine gathering of personal life story information, which helps staff in wards have a better understanding of the person. We were pleased to see that in a majority of cases (60%, 172) life story information was recorded, and in half of these cases we felt that information was being gathered well, with a meaningful life history and details about the individual person's preferences, interests, and about important people and events in their life. In a few cases where the patient had only recently been admitted

<sup>31</sup> Royal College of Nursing (2013) *Commitment to the care of people with dementia in hospital settings* <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2013/january/pub-004235.pdf>

<sup>32</sup> Scottish Government *Standards of Care for Dementia in Scotland* (Edinburgh, 2011) <http://www.gov.scot/resource/doc/350188/0117212.pdf>



(14%, 40) we saw no information, but we understood that the routine gathering of information would not have started. In a fifth of cases (19%, 55) we saw no information recorded, and our view was that we would have expected to see that information had been gathered and clearly recorded in files, using one of the range of formats available, such as the 'Getting to know me' document<sup>33</sup>.

We saw that the care planning documentation used in community hospitals had a very clear focus on physical health care needs. Most hospitals were using pre-printed sheets, often using the same documentation used in acute hospitals. While some documentation we saw did include sections about psychological wellbeing or cognitive functioning, most of the standardised care planning forms mainly recorded physical healthcare interventions, and whether tasks associated with physical care needs were carried out. In several health board areas we did hear that care planning documentation was being reviewed, because of concerns that care plans were not enabling staff to record interventions relating specifically to a patient's dementia, such as approaches to supporting the maintenance of skills in activities of daily living, social and cognitive stimulation and communication needs. We saw, for example, new paperwork being piloted in NHS Tayside. In many areas the care plan format was mainly a tick box format, which may be adequate for physical health care issues and tasks relating to physical health care, but often has little scope for free text entries which would detail nursing interventions relation to a patient's dementia.

In a very few cases plans had information about a patient's abilities and skills, and how their dementia impacted on their self-caring abilities. In one case we did see a good plan which detailed the personal care tasks the patient could do independently, and how they could be supported to retain this ability, but it was unusual to see this level of information recorded.

We looked at whether care plans included plans for identifying and reducing stressed/distressed behaviour. We felt it was important to do this, because the stress of being in a hospital environment can lead to, or exacerbate, distressed behaviours. The 10 point national action plan developed by the Dementia Standards in Hospitals Implementation and Monitoring Group, which is mentioned in the policy context section, has as action number nine, "Minimise and respond appropriately to stress and distress". We were aware, during the visits, that many of the patients with a diagnosis of dementia were settled in wards, and did not appear distressed or agitated. We also saw that most patients were in hospital following a fall, or because of physical health issues, and in most cases we could see that physical health care issues were well addressed in care plans, with good attention on physical healthcare management. However, we only saw evidence of care planning for stressed/distressed behaviour in a few cases (16%, 47). We also saw a number of patients where nursing staff were clearly providing care to patients who were often stressed, distressed or agitated, and where we felt a specific care plan should have been in place.

Where we saw examples of good care plans relating to stressed/distressed behaviour this was often associated with good input from specialist mental health services. In Blairgowrie Hospital we noted an "excellent record of assessment and advice and guidance for ward staff from the dementia liaison nurse". We saw other good care plans;

<sup>33</sup> [https://www.alzscot.org/information\\_and\\_resources/information\\_sheet/3472\\_getting\\_to\\_know\\_me](https://www.alzscot.org/information_and_resources/information_sheet/3472_getting_to_know_me)



in Falkirk Community Hospital a care plan for stressed/distressed behaviour explained clearly how staff could minimise situations, with concrete examples; in the Royal Northern Infirmary, a care plan detailed specific distraction techniques to be used for that individual patient, and staff were also using ABC charts (a way of understanding agitated behaviour in relation to what happened beforehand and as a consequence) to help identify triggers for agitated behaviour.

We would expect to see staff using person-centred evidenced-based interventions such as the Newcastle Model<sup>34</sup>, which provides an approach to understanding behaviour that challenges in terms of needs which are unmet, and to developing effective interventions appropriate to the needs of the person. Often if there was a care plan which referred to distressed or agitated behaviour there were no details of the specific interventions staff could use to reduce the stress being experienced by the patient. One care plan, which did identify issues with agitation, simply said “distraction is the plan”, and in a number of cases we saw reference to using distraction or re-direction or re-assurance, without recording specific approaches which have had good outcomes for the individual patient, in providing re-assurance or successfully re-directing them. We would expect to see information in an individual person-centred care plan about how approaches such as distraction or reassurance should be offered to that patient, based on an understanding of the person as an individual and what has been found to work for them.

We also saw a number of cases where there was no care plan for stressed/ distressed behaviour, but where staff were recording that the patient was at times stressed or agitated. Sometimes after discussion with staff in the ward we felt that they were responding appropriately to stressed behaviour, but that this was not being recorded well. In one case the Commission visitor’s view was that “staff have found positive ways to engage and reduce agitation but this is not formally recorded and appears to rely on verbal sharing...” Of the 57 cases where we felt a care plan for stressed/distressed behaviour should be in place but was not, 53% (30) were being prescribed medication to be given ‘as required’ for agitation. We understand that medication has its place in treatment, and issues about medication are discussed in a separate section of this report. Where ‘if required’ medication is prescribed for agitation, we would also expect to see a care plan which sets out other interventions staff should use to minimise a patient’s stress and agitation.

We have made a recommendation about care planning.

<sup>34</sup> Jackman, L, & Beatty, A (2015), 'Using the Newcastle Model to understand people whose behaviour challenges in dementia care', Nursing Older People, vol. 27, no. 2, pp. 32-39. <http://journals.rcni.com/nursing-older-people/using-the-newcastle-model-to-understand-people-whose-behaviour-challenges-in-dementia-care-nop.27.2.32.e666>

## Medication prescriptions and review

### What we expected to find

Psychotropic medication has a role in treatment and symptomatic relief for some people with dementia, but not all. The decision to prescribe medication should only be made following individual assessment. Psychotropic medication should not be prescribed routinely or indiscriminately.

Where psychotropic medication is prescribed 'if required' for agitation, there should be a clear care plan detailing when and how the medication should be used. This should be a later stage in the individual's care plan for stressed and distressed behaviour, if they remain distressed following earlier planned support and interventions.

The reduction of inappropriate use of psychoactive medication for people with dementia was part of the first Scottish Dementia Strategy, published in 2010, and, while much work has been done, this remains a focus of the third Dementia Strategy.

### What we found

We recorded whether or not psychotropic medication was prescribed for 243 (85%) patients whose care we looked at. 132 (54%) of those individuals were prescribed psychotropic medication, and 111 (46%) were not. This is a snapshot which records what we found on the day; we were not able to look at what medications patients had been taking before admission.

On our visit to patients with dementia in general hospitals in 2011<sup>35</sup>, we found that 46% of patients whose care we reviewed were on psychotropic medication, while on our visits to dementia continuing care wards in 2014<sup>36</sup>, 84% of patients were on at least one psychotropic medication.

For those we recorded were receiving psychotropic medication, we documented details of medication prescribed in 95/132 (72%). 44 (46%) of those patients were prescribed an antidepressant, 37 (39%) a benzodiazepine, and 41 (43%) an antipsychotic. This includes prescriptions for medications 'if required' for agitation. 71 (75%) of these people were prescribed 'if required' medications. 12 (13%) were prescribed a cognitive enhancer (an anticholinesterase inhibitor or memantine).

### Review of psychotropic medication

We looked for documentation of review of psychotropic medication for the 127 patients who were prescribed psychotropic medication, excluding five patients who were on a cognitive enhancer alone.

We found evidence of review of the continuing need for this medication in 83 (65%) of these 127 patients. This had taken place within the last three months for all but two

<sup>35</sup> The Mental Welfare Commission for Scotland (2011) *Decisions for Dignity* <http://www.mwscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf>

<sup>36</sup> The Mental Welfare Commission for Scotland (2014) *Dignity and Respect – our visits to dementia continuing care wards* [http://www.mwscot.org.uk/media/191892/dignity\\_and\\_respect\\_-\\_final\\_approved.pdf](http://www.mwscot.org.uk/media/191892/dignity_and_respect_-_final_approved.pdf)

patients (we did not record the date of the last medication review for those two individuals, who were each in their fourth month on the ward).

For 44 of these 127 patients (35%), we did not record finding evidence of review of the continuing need for psychotropic medication. A high proportion of these people had been admitted for only a short period of time. 28 (64%) had been admitted for less than a month, and eight of those for less than a week. In some of these cases it was appropriate that a further review of psychotropic medication had not yet been undertaken since admission. Also, some people will have been prescribed medication on admission that they had already been taking for some time.

There were four patients who had been in the ward for more than three months for whom we recorded that we could not find evidence of review of the continuing need for psychotropic medication (3% of the 127 patients). We noted that one of these patients was only prescribed 'if required' medication, and had received this only once in six months.

We consider that these figures show that most patients who were prescribed psychotropic medication were having reviews of their continuing need for this.

For the 132 people we recorded were prescribed psychotropic medication, including those on cognitive enhancers alone, 38 (29%) had had their medication reviewed in consultation with a psychiatrist or community psychiatric nurse. 80 (61%) had not. We did not record this information in 14 (11%).

We appreciate that input from a psychiatrist or mental health nurse to medication reviews may not always be required. However, we would expect that input from a mental health specialist should be readily available, where this would be beneficial.

For 43 people prescribed more than one psychotropic medication, there was evidence that medications were being reviewed in consultation with a pharmacist in 16 (37%). This is important because of the risk of drug interaction and side effects in an elderly population. There was no such evidence in 22 (51%), and only five of those 22 patients had been in the ward for less than one month. We did not record this information in five (12%). We have made a recommendation about pharmacy input.

### **Medication prescribed 'if required' for agitation**

For the 287 patients whose care we looked at, we recorded that 76 (26%) were prescribed medication 'if required' for agitation and 204 (71%) were not. We do not have that information for seven patients (2%). The drug type most commonly prescribed 'if required' for agitation was benzodiazepines, with lorazepam prescribed most frequently.

We were disappointed that more than half the 76 people prescribed 'if required' medication did not have a care plan for the use of this medication. We recorded finding a care plan for this in only nine cases (12%). We did not record whether or not there was a care plan in 27 cases (36%). We have made a recommendation about management of stressed and distressed behaviours.

## Rights

### What we expect to find

All patients have the right to expect good quality care and treatment in hospital. We expect to see that patients with dementia are treated with dignity and respect. We expect that their capacity to consent to medical treatment is assessed, and that there is compliance with legal requirements in respect of treatment. We also expect that no patients are effectively detained in hospital without legal authority (unauthorised deprivation of liberty), as this denies them safeguards under mental health legislation.

### What we found

#### Capacity and treatment authorisation

Where a patient lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 (s47) of the Adults with Incapacity (Scotland) Act 2000 (AWIA) must be completed by a doctor. The code of practice for Part 5 of the AWIA<sup>37</sup> also recommends that doctors use treatment plans to accompany s47 certificates, particularly with patients requiring multiple or complex healthcare interventions, which many patients we saw or reviewed did need.

When we visited general hospitals in 2010<sup>38</sup> we found that very few people with dementia had had their capacity to consent to medical treatment assessed and recorded, and even fewer had a completed s47 certificate in place. We were pleased to see that this was not the case in the community hospitals we visited, and that the question of whether patients could give valid consent was clearly being considered by doctors in the large majority of cases.

We looked at whether a s47 certificate was in place and found these for 211 patients (74%).

The decision about whether a patient has capacity to consent to treatment is a clinical one, which has to be made by the doctor treating the patient. Where we did not see a s47 certificate in place, we considered whether we thought a certificate might be appropriate. In 27 cases (9%) Commission visitors thought that a certificate was probably necessary. In a few of these cases the doctor had recorded their view that the patient had capacity, but in 21 cases an assessment of capacity to consent was not recorded.

We also looked at whether there were treatment plans in place to accompany s47 certificates, and of all the cases with a s47 certificate 86% (181) did have a treatment plan. This is not a legal requirement, but most of the patients with dementia in community hospitals have complex healthcare needs, which would indicate that a treatment plan would be good practice, and we were pleased to see such a high number of plans in place.

<sup>37</sup> *Adults with Incapacity Act Code of Practice for Practitioners Authorised to Carry Out Medical Treatment or Research Under Part 5 of the Act* <http://www.gov.scot/Publications/2010/10/20153801/0>

<sup>38</sup> The Mental Welfare Commission for Scotland (2011) *Decisions for Dignity* <http://www.mwcscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf>

## Unauthorised deprivation of liberty

In each hospital, we looked at arrangements for getting into and out of the wards. A very few wards (11%, 8) had a locked door policy, and most wards had open doors. A minority had key pad or push button entry systems. Where wards had open doors, in almost all cases doors were locked overnight, for safety reasons. In one hospital we were told that the ward door had been locked recently when a patient in the ward was detained.

Following a review of patient notes, and any conversation with the patient and/or relative or carer, and discussion with ward staff, Commission visitors were asked to record their views about whether there were issues about possible unauthorised deprivation of liberty, or about the patient effectively being detained in hospital with no legal authority. In a very few cases, (5%, 14 out of 287) we felt there were possible issues, and in nine of these 14 cases we felt we needed to follow issues up on the day. In five of the cases we talked about possible deprivation of liberty issues with ward staff, and in one case we were able to discuss the issue with the doctor who was in the ward. In one case the patient was detained under mental health legislation after our visit. We consider that detention is appropriate when a doctor feels that the criteria set out in legislation are met, as the safeguards which are in legislation are then in place for patients.

In all 14 cases where we identified possible issues about unauthorised deprivation of liberty, we said that information in files indicated that a care plan for responding to stressed/distressed behaviour would be appropriate, but was not in place. We also looked at prescribed medication in these cases, and noted that in five cases medication was prescribed to be given 'as required' for agitation, and that in nine cases psychotropic medication was prescribed, with medications reviewed in consultation with a psychiatrist in five of these cases.

When gathering information about arrangements for getting into and out of wards, and thinking about deprivation of liberty issues, we noted that in five hospitals electronic location devices were being used. These are systems where a patient wears an electronic wrist tag, which sets off an alarm if they leave the ward, alerting staff when a particularly vulnerable patient is leaving. In only one hospital were we told that a clear policy was in place for the use of this technology, with relatives involved in giving consent. We have made a recommendation about this.

Overall we were pleased that we identified potential issues about unauthorised deprivation of liberty in very few cases on our visits.

## Restraint

The Commission understands that in certain circumstances restraint may be appropriate, and that restraint, in its broadest sense, includes the use of technology to prevent the person leaving the ward. We have published guidance on the use of restraint in care settings, which includes general principles to be applied when considering the use of restraint<sup>39</sup>.

<sup>39</sup> The Mental Welfare Commission for Scotland (2013) *Rights, risks and limits to freedom*, [http://www.mwcscot.org.uk/media/125247/rights\\_risks\\_2013\\_edition\\_web\\_version.pdf](http://www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf)

When we reviewed files we looked at whether there was evidence of restraint being used, and at whether there were relevant risk assessments on file. In a minority of cases (27%, 77) we did see that restraint was being used. In most cases the form of restraint was the use of bed rails. In a very few cases electronic location devices were being used for specific individual patients, but this did not seem to be used in a blanket way. We also saw that in a very few cases other technology was being used. For example, a telecare alarm being fitted to a chair where there was an identified falls risk, to assist with falls prevention.

With regard to the use of bed rails, we said in the previous themed visit report six years ago about visits to people with dementia in general hospitals<sup>40</sup> that some wards appeared to use them indiscriminately, with little attention paid to whether they were needed or not. On these visits the overall situation had improved, although we still had some concerns. There was evidence in a majority of cases that appropriate risk assessments were completed (68% of cases, 52 out of 77). We also saw good records in some files of assessments being completed which clearly identified that the use of bed rails was not appropriate. In NHS Highland for example, mandatory nursing assessments include specific risk assessments, and in several cases in community hospitals there were clear statements that bed rails were not to be used, usually because there were identified fall risks if an individual patient tried to climb over bed rails. This indicates that bed rails were not being used indiscriminately for every patient who has dementia in community hospital wards.

However, while assessments of the need for bed rails were in place in most cases where rails were being used, in some files there was no information about a specific assessment. In a few hospitals, files would simply record that bed rails were in place “as per hospital policy.” We did also find in one case that there was a bed rail assessment which had concluded that the use of rails was not appropriate, but bed rails were being used, and this was picked up on the day with the ward manager.

In a third of cases where restraint was being used (34%), there was little or no evidence of regular reviews. In most cases the need for bed rails was kept under review, and indeed in a number of hospitals the continuing need for the use of bed rails was being considered daily, as part of a ward rounding process (a structured process of carrying out regular checks on individual patients) or a shift assessment. We saw in some hospitals that bed rail reviews were part of wider care plan review process, for example, with the use of rails reviewed within a falls prevention care plan review. There were also examples of changes in a care plan following a review, with a hi-lo adjustable bed being provided after a review of the use of bed rails in one hospital.

We have made a recommendation about the use of restraint.

### **Involvement of welfare proxies**

When we visited people with dementia in general hospitals in 2010 very few people had a welfare proxy<sup>41</sup>. We also saw that when a welfare proxy was in place, staff did not

<sup>40</sup> The Mental Welfare Commission for Scotland (2011) *Decisions for Dignity*  
<http://www.mwcscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf>

<sup>41</sup> A welfare proxy is a welfare guardian or someone who had been granted welfare powers of attorney.



know if their powers included the power to consent to medical treatment in about half the cases.

Since then, improvements have been made to post-diagnostic support for people diagnosed with dementia. The Scottish Government NHS Local Delivery Plan Standards include a minimum of one year's support after diagnosis. This support is based on Alzheimer Scotland's Five pillars model<sup>42</sup>, and this commitment has been continued in the third dementia strategy. It has been extended to offer people diagnosed early with this support for the duration of their time living with dementia, or until such time as their needs change, and they require greater care coordination. This includes advice on planning for the future, including making powers of attorney, and it would appear that this has had an impact.

On these visits we saw clear evidence that people have been planning ahead and making decisions about giving someone the power to act on their behalf in situations when they are not able to make decisions themselves. In a third of cases (36%, 104 of 287) we saw that a patient had previously granted powers of attorney, almost always to a family member. In a few cases a guardianship order was in place (2%, 5), or was being applied for (9%, 26). When we examined patients' files, we found that in a few cases the specific powers were not recorded in care files, but contact details of welfare proxies were recorded and readily available to staff in most cases (91%). Where a welfare proxy is in place, staff in community hospitals are reliant on the proxy making them aware of their powers, and confirming this by giving them a copy of any powers, and we did see in some cases that staff had been asking for copies of powers which had not been provided. These could be obtained from the Office of the Public Guardian.

Welfare proxies can have the power to make a range of welfare decisions, including consenting to medical treatment, and we only saw one case where the powers granted did not include healthcare powers. In a majority of cases care files showed that welfare proxies were being consulted appropriately about treatment decisions. Only in a very few cases (4) did we feel that proxies did not seem to be consulted. Although in a few cases (19) we did not see evidence of consultation in files. Proxies with relevant welfare decision-making powers must be consulted about treatment decisions, and about other welfare decisions, where it is reasonable and practicable to do so.

### **Staff understanding of proxy decision-making measures**

We discussed cases with some staff where it was clear that they were not sure about the role of guardians, attorneys, or relatives who had no legal authority, exercising powers. For example, we spoke with some staff, both medical and nursing, who did not seem to be aware that if a relative did not have proxy powers they could not insist on making a specific decision which staff thought was not in the adult's best interests. Staff were also unsure about issues arising about granting powers of attorney if the adult might not have capacity to do this, for example where staff had been told by relatives that a solicitor would be coming in to get power of attorney granted, when the adult had been assessed as lacking capacity.

<sup>42</sup> Alzheimer Scotland, 2011, *Five pillars model of post-diagnostic support*, [https://www.alzscot.org/campaigning/five\\_pillars](https://www.alzscot.org/campaigning/five_pillars)

We think staff in community hospitals should have access to training about the practical application of incapacity and mental health act legislation, in particular about how decisions can be made for adults who do not have capacity, and about the principles which should guide decisions. NHS Education for Scotland delivers training on the suite of Scottish adult protection legislation as part of their training programmes and masterclasses, and the legislation is included in a number of their learning resources (see Appendix 2). There is also information on the Rights-based care, and legal and ethical issues pages on the Dementia Managed Knowledge Network<sup>43</sup> and the Commission's website<sup>44</sup>.

The Commission has produced good practice guidance for staff in general hospitals<sup>45</sup>.

We have made a recommendation about staff training covering this issue.

<sup>43</sup> <http://www.knowledge.scot.nhs.uk/dementia/rights-based-care-and-legal-and-ethical-issues.aspx>

<sup>44</sup> <http://www.mwcscot.org.uk/the-law/>

<sup>45</sup> The Mental Welfare Commission for Scotland, 2017, *Good practice guide: The Adults with Incapacity Act in general hospitals and care homes* [http://www.mwcscot.org.uk/media/339351/awi\\_in\\_general\\_hospitals\\_and\\_care\\_homes.pdf](http://www.mwcscot.org.uk/media/339351/awi_in_general_hospitals_and_care_homes.pdf) and 2015, *Quick Guide: Power of attorney, for staff in hospitals and care homes* [http://www.mwcscot.org.uk/media/241253/poa\\_leaflet\\_care\\_homes.pdf](http://www.mwcscot.org.uk/media/241253/poa_leaflet_care_homes.pdf)



## Activities

### What we expect to find

We expect to see an appropriate range of meaningful activity provision for patients with dementia in wards.

### What we found

Community hospitals are based in communities close to where patients live, and also close to families/friends who live locally. Most carers we heard from told us that they could visit when they wanted to, and almost every hospital had flexible visiting times, with opportunities for extended visiting, so contact with families and friends was an important part of activities within wards. Though many hospitals are in old buildings, with beds in bays or dormitories, and with limited space for activity provision.

Most patients had been admitted to a community hospital from an acute hospital, and from the information we gathered, most had been admitted following a fall or injury, or because of other physical illness. One of the main functions of community hospitals is to provide rehabilitation services, and on our visits we looked at the provision of therapeutic activities. As we say in the staffing section in this report, we found that wards had good input from OT and physiotherapy, with OTs and physiotherapists being integral members of MDTs. We were pleased to see this strong focus on therapeutic rehabilitation activity, helping patients regain mobility and independence following falls or episodes of physical ill health.

Improving care in hospitals is a key part of the national dementia strategy, and 10 dementia care actions for care in hospitals were agreed to support the implementation of commitment 10 of the 2013-16 strategy. Healthcare Improvement Scotland has reported on some of the work being undertaken in this area across Scotland<sup>46</sup>. The report gives case examples of positive outcomes providing different meaningful activities for people with dementia in hospitals. We know that admissions to hospital can trigger a stress and distress response, but that involvement in appropriate activities can reduce anxieties, stress and boredom, and can impact on how settled a patient with dementia will be in hospital, as well as help maintaining skills and abilities. We asked questions on these visits about the availability of meaningful activities in wards.

20% (21) of carers we heard from felt their relative's skills were not being maintained and 38% (39) felt this was being done partially. 30% (31) were happy that skills were being fully maintained.

*Very satisfied. The quality of care is excellent and the staff are wonderful. The physio started on admission which has helped a lot. He was bent double before. The difference has been amazing. (Carer)*

*Feels she is well cared for. However she was transferred for increased physiotherapy following her fall and fracture and has had little input so now chair-bound. (MWC visitor)*

<sup>46</sup> Focus on Dementia: Supporting improvements for people with dementia in acute care, June 2016, <http://www.gov.scot/Resource/0042/00423472.pdf>

We looked at whether individual patient files included a care plan for the provision of social and cognitive stimulation. We were disappointed to see very few activity care plans (8%, 22), and even where there was a care plan, this often had little or no information. We saw one plan, in Falkirk Community Hospital, which detailed relevant reminiscence and memory stimulation topics for staff, but this was very much the exception. We also looked for evidence of the patient's participation in meaningful activity in the previous week. We only found information in 16% (46) records, but we did see that in a majority of the small number of cases where there was an activity care plan, there was a record of patients engaging in activities.

Although there was very little evidence of care planning or recording of activities, we did hear examples of ward-based activities which patients with dementia could participate in. We heard about a range of activities which were available, including visits from therapy dogs, Music in Hospitals (a charity bringing live music into hospitals), iPods with playlist for life music (playlists of music which means something to an individual patient), board games and quizzes, craft and art groups, and various exercise groups including chair exercises. We saw that a number of hospitals had volunteers coming in to wards to provide activities, and some hospitals told us that they would use information about a patient's life history and interests collected in "Getting to know me" forms to try to encourage patients to engage in activities or in one-to-one conversations with staff. We also saw that in some hospitals in-patients with dementia could access other services in the hospital. For example in Campbelltown Hospital patients could go to the dementia day hospital to join in activities there.

We also asked staff whether patients who were physically mobile were able to get out of the ward. We were told that in a minority of wards (39%), staff felt that patients had sufficient opportunities to get out, with patients in a smaller minority of wards (34%) having opportunities to go out which staff felt were occasional but insufficient, and with patients in a few wards (20%) only having opportunities to get out if relatives took them out.

While we did hear about different activities which could be going on in wards the overall picture was of very limited activity provision. We were aware that some patients could not have participated in activities, because of very poor physical health, but we would have hoped to see more provision, particularly because over half of patients with dementia had been in hospital for over a month, with 18% (52) being in-patients for over three months.

We saw a number of examples of good practice in relation to the provision of activities. A few hospitals had activity co-ordinators, or had plans to create posts, and provision was good where a specific worker had responsibility for arranging activities. In Edington Hospital we were told that the local group, Friends of Edington, has funded an activity co-ordinator who arranges tailored individual and group activities, including reminiscence work, craft groups, trips out of the hospital, music in hospitals, reflexology, and supporting couples to organise 'date' nights when one is in hospital. On this visit the Commission visitor specifically commented on the "great individualised (activity) plans thanks to a very enthusiastic activity co-ordinator".

Some hospitals had built good links with local community groups, businesses, and local authority leisure services. Our assessment of activity at Lightburn Hospital, for example, was that "staff are creative in identifying local resources and using them, and see this as

an important part of their care". In Lightburn we saw the active involvement of volunteers, therapets, music in hospitals and playlist for life, school choirs, patients attending football matches, and the use of reminiscence boxes provided by Glasgow City museums. At Turner Memorial Hospital we heard how a range of groups and businesses help with activity provision: the hospital League of Friends, the local Tesco, local schools and the local pipe band, the local WRVS, the local Keith Festival (a traditional music festival). We saw a range of activities, from therapets to patients having tablet computers and e-books, with a well organised activity corner, and on our visit we saw senior pupils from the secondary school who come in weekly to help with activities.

Some hospitals have been active in developing their environment. At Whitehills Hospital we saw a sensation room which had been created, and a café area in the ward, with volunteers in the ward daily, and with rummage boxes and twiddle muffs available to be used. In this hospital we saw an example of staff using a creative approach to providing activities - one patient had a group of friends who met at his house every week, to listen to jazz music, and they called this their jazz group, and staff had encouraged all the group to come into the ward and use the café area to keep having their jazz group meeting.

The activity programme at the Royal Victoria Hospital in Dundee has a very successful policy of inviting carers to join physiotherapy and OT groups. Staff told us that this helps with motivation for the individual, and that carers feel involved and more confident about carrying out these tasks with their relative after discharge.

While there were examples of good activity provision, in 45 (57%) of the 78 wards Commission visitors felt that provision was limited or very poor. Staff in wards could often be frustrated at the lack of activity provision, and could see the benefits of having structured meaningful activities in wards. We were told in one hospital that there was no provision, which was "very hard for staff" because patients can be in for over six months with no stimulation.

In wards where there was no activity co-ordinator, and no in-reach into the ward from community or voluntary sector groups, wards were reliant on nursing staff or healthcare assistants providing activities. We heard from various staff members in wards how they would try to spend time either individually with patients or arranging an activity, but that priority has to be given to nursing and clinical tasks, or providing personal care. Therefore, it is common in community hospital wards that staff cannot plan to do activities, but that activities can be organised on an ad hoc basis, when time is available depending on the clinical needs of patients in the ward at the time.

As well as gathering information from staff and files about activity provision, we asked patients themselves if they felt there was enough to do on wards. Some people could not answer this question, or said clearly that they were not interested in activities, often because they did not feel physically well enough, or because they were just happy with visits from their families. When people did give us their views about activities in the wards, a majority (56%, 47 of 84) were positive about having things to do, but a minority (44%, 37 of 84) did say clearly there was not enough to do, with a few people saying explicitly that they get bored. Patients who wanted more to do in wards often did talk about enjoying going off the ward with family, but for many people this would not be a very frequent occurrence, and there plainly were patients in wards on our visits who would have wanted more meaningful activities while they were in hospital.

Patients with dementia who are in hospital should have access to a range of activities which provides them with a meaningful day. The provision of activities is an integral component of dementia care. On these visits we could see that many patients were too physically frail or unwell to participate in activities, that many patients had very good contacts with family and friends who were visiting regularly, and that most patients were in hospital for some rehabilitation following physical injury or illness. We did see examples of how staff in wards in community hospitals were given time and encouragement to develop activities, either provided by staff themselves or by volunteers and groups from local communities. We feel that because community hospitals are based in communities there are opportunities to build community links, and to have input from community groups and volunteers providing more structured activities. We have made a recommendation about this.

## Discharge and delayed discharge

### What we expect to find

We expect planning for discharge from hospital to start as soon as is appropriate. People should be discharged from hospital, with appropriate care and support in place, when they no longer need in-patient care and treatment.

### What we found

A number of people we spoke with on the visits told us clearly that, while they were satisfied with their care and treatment in hospital, they wanted to be home.

We know that a hospital ward is not a good environment for a protracted and unnecessary stay. As well as having an impact on other admissions, a delayed discharge can have adverse effects on patients with dementia who remain in hospital when they do not need to. This can have an impact on their health and well-being, and can lead to patients acquiring avoidable ill health, increasing the risk of infection and of a decline in their daily living abilities. This was highlighted in a report from the Information Services Division, part of NHS Scotland, in 2016, which said: “It is very clear that being delayed in hospital can be harmful and debilitating – and in the case of older people, can often prevent a return to living independently at home. Reliably achieving timely discharge from hospital is an important indicator of quality and is a marker for person centred, effective, integrated and harm-free care. Older people may experience functional decline as early as 72 hours after being clinically ready for discharge and the risk increases with each day delayed in hospital. This increases the risk of harm and of a poor outcome for the individual and further increases the demand for institutional care or more intensive support at home”<sup>47</sup>.

On the visits we gathered information from staff and from notes about the plans for each person moving on from the ward. Where someone was ready to move on from the ward, we looked at whether they were returning home with either the same support as pre admission, or with additional support, were returning to a care home or were waiting for a new admission to a care home setting, or waiting for other plans, including a transfer to another NHS unit. Where the plan was for a new admission to a care home, we looked at whether consideration had been given during discharge planning to providing support to enable the person to return home.

In about half of cases (45%, 128) information from staff and/or notes indicated that patients were not ready for discharge because a further period of assessment, or in-patient care and treatment or rehabilitation was needed. In a very few cases (9%, 26) it was recorded that guardianship applications were in the process of being made, while in a quarter of cases (27%, 77) it had been identified that a residential placement was required.

In about a fifth of cases (18%, 53) arrangements had to be made for the provision of home care support. In about a quarter of these cases (12) patients were waiting for a decision to approve funding for home support, while in about three quarters (41), delays

<sup>47</sup> ISD Scotland, October 2016 [http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/docs/Delayed\\_Discharges\\_Background\\_and\\_Glossary.pdf](http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/docs/Delayed_Discharges_Background_and_Glossary.pdf)

were caused by the need to organise support. In many of these 41 cases the patient had been receiving support at home before their admission to hospital, but the package of support was automatically cancelled after a short period of hospital admission. This then meant that the original support workers could not automatically start providing support again, and that the patient had to wait until new support arrangements could be organised. This is concerning as it means patients with dementia are remaining in hospital when they do not need to be there, and they are at risk of losing skills they need to remain independent. It also means that there may be a loss of continuity of care, with new care staff when they do return home, which can be particularly difficult for people with dementia to adjust to. We have made a recommendation about this.

In a very few cases arrangements to discharge a patient from hospital could not be finalised because there were ongoing discussions with relatives about the arrangements which should be in place, to provide safe and appropriate support after discharge.

We also asked ward managers to complete a sheet in advance of our visit, providing some information about each patient in their ward at that point who had dementia or was being assessed. This information included information about whether the patient was formally recorded as a delayed discharge patient, and the reasons why. The information from these sheets did not match exactly the information from our case note reviews. Sometimes this was because patients were discharged immediately before our visit, and on a few occasions on the day of our visit. Sometimes staff in a ward were clear that a patient was ready to move on, so assumed they were a delayed discharge patient, but they had not yet been formally listed as a delayed discharge. However the information from ward managers did give the same overall picture, that in about half of cases patients were not ready for discharge, and that in a minority of cases arrangements needed to be made for a residential placement or for home care support to be in place.

When we visited people with dementia in general hospitals in 2010<sup>48</sup> we said that when patients were admitted from their own homes “the presumption should be that they will return to their own homes and that alternatives should only be sought if this is not practicable.” We were concerned then about the high number of people not returning to their own homes. On these visits to community hospitals we looked for evidence in files that consideration was being given to discharge home rather than to a care home. In a very few cases (9%, 25) this was not applicable because the patient had not been living at home before their hospital admission. We were pleased to see that in most cases where information was available in files (81%, 205 of 252 cases) we saw that appropriate consideration was given to discharge home, often with good information about assessments completed by OTs and/or physiotherapists to assist in the process of discharge planning. In a minority of cases we saw that plans for moving on were for patients to move to a residential placement (33%, 67 of 205), but we did think that appropriate consideration was being given to the option of the individual patient returning home, and that decisions that this was not appropriate were based on assessments about whether the person could be supported safely in their own home.

<sup>48</sup> The Mental Welfare Commission for Scotland (2011) *Decisions for Dignity*  
<http://www.mwcscot.org.uk/media/53187/Decisions%20for%20Dignity%202010.pdf>

## How people feel about their stay

### What we expect to find

We expect patients to feel they are treated well and are experiencing good quality care. Staff should be spending time with them and be easily available, and we expect patients, as much as possible, to be involved in decisions about their care and treatment.

### What we found

We had a set of questions we asked patients we met on the visits, to gather their views on how they felt they were being treated in hospital. These included general questions about their experience, and specific questions about issues, including how much information they were given about their treatment and how safe they felt in the ward.

149 patients (52%) were not able to participate in a discussion with a Commission visitor. The main reasons for not being able to talk to patients were that they were in the later stage of dementia, or that they were too physically unwell to speak to visitors when we were in the ward. Although some people did say very clearly that they did not want to speak to us. 138 people (48%) were able to tell us something about how they felt about their stay in hospital. In some cases (45, 16%) patients engaged well in an interview, and expressed very clear views, but for most patients we were able to talk with participation was limited.

We asked general questions about what it was like to be on the ward, and how people felt they were being treated, and got responses from 134 people (47% of the total). Two people described their experience as terrible, and they were both people who were often unsettled in the ward, displaying stressed and distressed behaviours. Several people said that they didn't like being in hospital and would rather be home, but that they were happy with their care in hospital. One person told us for example that staff were nice and attentive "but it's not like home". Almost all the rest of the people who told us how they felt about being in the ward, and about the staff supporting them, were positive. A lot of patients were quite neutral about what it was like on the ward, telling us it was OK or alright, but often people would then add that they felt staff were treating them very well. As an example one patient said that "it's alright.... (there's) nothing else for it", but then said "staff can't do enough for me."

Of the 134 individual patients who were able to comment either fully or in a limited way on their treatment, two expressed adverse comments. A minority felt their treatment was all right but were quite neutral (28%, 37), about half (48%, 64) were positive, and the rest (23%, 31) were very positive, and often made specific comments about what they felt satisfied with about their care and treatment.

Examples of the positive comments were:

*They are all wonderful, they are all so kind and thoughtful....they can't do enough for you, they work very hard. (Patient)*

*Nurses are great, plenty of them and they can't do enough for me, anything I fancy is no bother. (Patient)*

*The staff are helpful and look after me well. There's staff helping me walk.....the nurses and other staff help me get back on my feet. (Patient)*

A number of patients told us about the quality of interactions with staff, often describing staff as kind, warm, caring and helpful. Patients also commented on how appreciative they were of all the staff in a ward, with one retired doctor saying he felt all staff, from nurses in charge to assistants and cleaners, were very good. Several patients said they could see how busy staff were, including one retired nurse who understood nurses had a lot of paperwork to do, but felt staff were still positive and attentive.

A couple of common issues were raised by more than one patient. Two people felt uncomfortable in a dormitory in the ward because of the lack of privacy, but otherwise both were happy with their treatment. Five patients said they felt that it was boring in the ward. Three of these patients had been in hospital for over a month, and one had been an in-patient for over three months. In each of these cases we could not see evidence the patient had participated in meaningful activity in the week prior to our visit.

We asked people if they felt they got enough information about their treatment and about what was happening in hospital. Of the patients we could talk with, a minority said yes very clearly, that they felt they got enough information (28%, 39 out of 138). A larger minority (35%, 48 of 138) were not able to answer this question. Of the rest of the patients we spoke to, many said they could not remember or were unsure. This will not be unusual if people experience difficulties retaining information, but does suggest that patients may need to be given information about their treatment and what is happening on a regular basis, or in different formats in addition to giving information verbally.

We asked patients about some specific aspects of their treatment in the hospitals, including whether they felt there was enough privacy, whether they felt safe in the ward, and whether they felt staff were always available to talk to them. Many patients were not able to answer specific questions. When patients could answer questions, a majority told us that they were shown around the ward when they came in (69%, 40 of 58). Only a very few (5%, 6 of 117) said they did not know how to get staff if they needed help, with the rest saying they would be able to alert staff and get attention. Only one person said they felt staff were never available to talk to, with most patients (86%, 105 of 122) expressing positive views about staff responding when they needed to talk to them. Almost all patients felt they had enough privacy (97%), and that staff used the name they prefer to be called when speaking to them (99%), and most patients were positive about being asked how they would like to be treated (84%, 63 out of 75). Twelve people did say that they did not feel they were asked how they would like to be treated, but apart from one person who did say “the doctor tells me what will happen rather than ask me what I’d like to happen”, the other eleven did not give any further specific comments. We were also very pleased to hear from almost every patient who could give us their view (99%, 116 of 117) that they felt safe in the ward, and in the one case where we were told they did not feel safe, we did think that the safety fears were related to their current illness.

We asked whether patients were aware of their right to advocacy, or had heard of advocacy services. Only three patients told us they had an advocate, with two saying that they had been offered advocacy support but did not want to use the service. A majority of patients who replied to this question (58%, 53 of 92) had either not heard of advocacy, or were not sure. A few patients who had not heard of advocacy did say that either they could speak for themselves, or that they were happy for family members to deal with things for them, but we would have hoped to see more knowledge about the



availability of advocacy services amongst the patients we met. This is particularly important, for example, where patients may need help in negotiating care packages, or where they are unable to express a view and may need uninstructed advocacy to safeguard their interests. It is important that staff are proactive in helping people access advocacy.

The Commission's recent advocacy report on a survey of advocacy planners and commissioners recommended that strategic plans are developed based on a local needs assessment, and information about unmet need and gaps in local provision, and that they should address barriers people may be experiencing accessing advocacy support.

We have made recommendations about information and advocacy.

## Staffing<sup>49</sup>

### Dementia expertise

51 wards (72%) had dementia champions on the ward team and a further 11 (15%) had access to a dementia champion who was based elsewhere. We were pleased to see this, as the dementia champions programme was originally focussed on staff working in acute general hospitals and only later cohorts included community hospitals. Dementia champions are trained to enhanced level on the Promoting Excellence dementia skills and knowledge framework<sup>50</sup>, and operate at ward level. They are usually nurses or allied health professionals, who have taken part in a specific training programme. Their role is to support colleagues in 'improving the experience, care, treatment and outcomes for people with dementia, their families and carers in general hospitals and at the interface between hospital and community settings'<sup>51</sup>.

The wards which have a dementia champion or access to one commented positively about the impact they have made. The most common areas were around; environmental improvements; helping to make wards more dementia friendly; providing training, either directly or supporting staff to access this; supporting the development of activities; providing input to care planning and supporting staff in managing stress and distress; and raising awareness of AWIA with staff and relatives.

49 (69%) of the wards we visited had access to a dementia nurse consultant<sup>52</sup>. Dementia nurse consultants are at the expertise level of the Promoting Excellence dementia skills and knowledge framework. They operate at NHS Board level, and have a lead role in taking forward the national agenda for improvement in dementia care, and supporting the work of the dementia champions. As would be expected with such a diverse range of hospitals the level and type of input varied considerably, however these wards told us they were available to provide advice and support when required and either provide or facilitate access to training.

The levels of specialist training within the nursing team varied considerably across the hospitals we visited, not surprisingly, given the variations in bed numbers and staffing establishment. Two thirds (65%, 46) had staff trained in identifying delirium and half the hospitals (49%, 35) had staff trained in the AWIA.

When we asked about specialist training in dementia care we found that of the 71 wards, 41% (29) had no-one with training in the Newcastle model<sup>53</sup> or other similar models for

<sup>49</sup> Returns from ward managers and staff were received from 71 wards.

<sup>50</sup> Scottish Government, 2011, *op cit*

<sup>51</sup> Ellison S, Watt G, Christie I, NHS Education for Scotland, April 2014, *Evaluating the impact of the Alzheimer Scotland Dementia Nurse Consultants/Specialists & Dementia Champions in bringing about improvements to dementia care in acute general hospitals*  
[http://www.nes.scot.nhs.uk/media/2711493/impact\\_evaluation\\_-\\_final\\_report.pdf](http://www.nes.scot.nhs.uk/media/2711493/impact_evaluation_-_final_report.pdf)

<sup>52</sup> Alzheimer Scotland, 2015, Shifting the paradigm together: Alzheimer Scotland Dementia Nurse Consultants and Allied Health Professional Consultants  
[https://www.alzscot.org/assets/0002/1161/FINAL\\_AS DNC\\_and\\_AHP\\_Review\\_2014-15\\_2\\_.pdf](https://www.alzscot.org/assets/0002/1161/FINAL_AS DNC_and_AHP_Review_2014-15_2_.pdf)

<sup>53</sup> Jackman, L, & Beatty, A (2015), 'Using the Newcastle Model to understand people whose behaviour challenges in dementia care', *Nursing Older People*, vol. 27, no. 2, pp. 32-39.  
<http://journals.rcni.com/nursing-older-people/using-the-newcastle-model-to-understand-people-whose-behaviour-challenges-in-dementia-care-nop.27.2.32.e666>

managing stress and distress. Given that all these hospitals will provide care to patients who have a diagnosis of dementia on a regular basis this issue needs to be addressed. We have made a recommendation about this.

When we discussed staff training, we heard comments from staff at a number of hospitals which indicated that there was a lack of clarity about the different levels of knowledge and skills required by staff at the different Promoting Excellence dementia skills and knowledge framework<sup>54</sup> levels. All staff working in health and social service settings should attain the 'dementia informed' level, and all staff with direct and/or substantial contact with people with dementia should attain the 'dementia skilled' level. In community hospital wards working with people with dementia, this means that clinical staff, including clinical non-registered staff such as healthcare assistants, should be at the dementia skilled level.

We gathered some supplementary information about training, covering 35 wards, during March and April 2018. 23 of these had some clinical registered staff at skilled level, more than half were at this level in 15 wards and in five all clinical registered staff were trained to this level. A slightly larger proportion had attained the lower, dementia informed level. 12 wards had all clinical registered staff at this level and a further 10 said some were.

Only eight wards said some of their clinical non-registered staff were trained to dementia skilled level, and only 21 wards said that any clinical non-registered staff were trained to the informed level, with only eight saying all were.

During our visits we were told that in some hospitals a large number of staff had completed or were undertaking training at higher levels on the framework. In two hospitals we were told that 16 and 23 staff had completed training at an enhanced level. While in two different hospitals we heard that over 20 staff in each hospital were undertaking LearnPro online training at an expertise level, although there is no such resource at this level, implying a lack of understanding of the Promoting Excellence framework.

We heard about a range of other training undertaken by staff in some wards, including training on delirium, 'Think Capacity, Think Consent' on using the AWIA in general hospitals<sup>55</sup>, and training on supporting people with dementia in acute care and palliative care for people with dementia.

Much of the training which had been undertaken was provided through online modules, although there were also externally-facilitated training courses and in-house training. The most common barriers to training identified were staffing constraints; difficulty in releasing staff, either due to lack of available staff to backfill, or due to budgetary constraints. Some wards mentioned that mandatory training, such as moving and handling and fire safety, took priority. Limited access to computers was also a barrier in some hospitals. Some wards said that staff were undertaking modules in their own time, unpaid.

<sup>54</sup> Scottish Government, 2011, *op cit*

<sup>55</sup> NHS Education Scotland learning resource  
[http://www.nes.scot.nhs.uk/media/1557644/capacity\\_and\\_consent-interactive.pdf](http://www.nes.scot.nhs.uk/media/1557644/capacity_and_consent-interactive.pdf)

We also asked about support and supervision for staff. A significant proportion of wards mentioned dementia champions, liaison nurses or nurse consultants as being a support to staff.

### Professional input

We looked at the level of multi-disciplinary input to wards.

Just over half of the wards we visited (56%, 40) were GP led. 89% (63) had input from a geriatrician, either on a regular or a referral basis

Staff said access to psychiatry was widely available (99%, 70) with the large majority (94%, 67) of the wards we visited having access to this on a referral basis and three with regular input from a psychiatrist. Only one ward told us they could not access psychiatry. However, psychiatrists only attended MDT meetings in 30% (21) of wards, and this was mainly on an individual request basis.

In almost all wards then we heard that access to psychiatry was by referral only. Some ward staff made specific comments about the benefits of having good input from psychiatry, for example providing advice and guidance and reviewing medication. In nine wards we did hear that there could be lengthy waits, or waits of a month or longer, for input from psychiatry. We consider that input from specialist mental health services should be easily accessible in all community hospitals, where this input is felt to be necessary to support staff who are managing complex issues relating to a patient's dementia.

Pharmacy input varied considerably. 82% (58) had access but only 69% (49) said input from a pharmacist was regular rather than by referral. Pharmacy attended MDT meetings, either on a regular or invitation basis, in just 37% (26) of wards. In contrast 15% (11) of wards told us they did not have access to pharmacy input to the ward, even on a referral basis. This is disappointing, given the important role pharmacists can play, in medicine reconciliation at the point of admission, and in providing advice and guidance on prescribing, including prescribing psychotropic medication, which is discussed in the medication section above.

Multiple comorbidities often exist in older people and may entail complex prescribing, especially when there is also a diagnosis of dementia. There are also often challenges which can arise from administering medications to people with swallowing problems or who require covert medication. We therefore think it is important that pharmacy input is available to all wards caring for patients with dementia.

None of the wards we visited had regular input from psychology. 69% (49) were able to access this on a referral basis, however, comments indicate that the level of access varied greatly with 12 wards, saying they rarely referred or commenting negatively on access due to waiting lists, with one ward saying they did not refer to psychology as this service was not required. Only five wards commented positively on the benefits of access to psychology. This would seem to indicate a lack of awareness amongst staff of the role of psychology and its value to patients with dementia.

OT was an integral part of the MDT in most wards. It was available on a regular basis in 90% of wards, with the rest being able to access it on a referral basis. OTs attended MDT meetings in 93% (66) of wards on a regular basis and to others on request.

Physiotherapy, dietetics and speech and language therapy were available to all wards on either a regular or referral basis.

We also looked at the availability of staff trained in palliative care. 20% (14) of wards had staff trained in palliative care within the ward team and a further 13% (9) had regular input from palliative care nurses. The remainder of wards, 66% (48) could access this service on a referral basis.

Social work input was available in all wards with 68% (48) having regular input, 32% (23) by referral only, and 63% (45) of wards having a regular social work presence at MDT reviews. Their role was identified as particularly important in discharge planning and liaising with care providers.

56% (40) of wards said that community staff attended either for individual reviews or pre discharge meetings

Other professionals who had input to the MDT on a referral basis were district nurses, liaison nurses from the local community mental health team and elderly mental health team, and advance nurse practitioners or specialist nurses such as tissue viability, diabetes or Parkinson's nurses.

82% (58) of wards felt satisfied with the level of multi-disciplinary input available to them.

Arrangements for access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health varies considerably. Some wards have to go through the GP or consultant who can make a referral to the local mental health team, whilst others can make a referral directly where they feel input would be beneficial. A small number of wards have regular input from a liaison nurse or community psychiatric nurse.

We have made a recommendation about access to specialist services.

## Conclusion

This is the first time the Mental Welfare Commission has visited community hospitals to look at the care and treatment of people with dementia.

The care and treatment provided is generally good, and community hospitals are valued by patients, and by carers.

However, much of the focus of care is on the physical reasons for which most patients were admitted, and we identified a range of ways in which care and treatment and the environment could be improved in relation to dementia.

## Appendix 1 – List of hospitals and wards visited

NHS Board	Hospital
Ayrshire and Arran	Arran War Memorial
	Biggart Hospital (Lindsay, McMillan & Urquhart)
	East Ayrshire Community (Burnock & Roseburn)
	Girvan Community Hospital
	Lady Margaret Hospital, Millport
Borders	Hawick Community Hospital
	Hay Lodge Hospital
	Kelso Hospital
	Knoll Hospital
Dumfries and Galloway	Castle Douglas Hospital
	Kirkcudbright Hospital
	Lochmaben Hospital
	Newton Stewart Hospital (Wards 1, 2a, 2b, 3)
	Thornhill Hospital
Fife	Cameron Hospital (Balcurvie & Balgonie)
	Glenrothes Hospital (Wards 1, 2, & 3)
	St Andrews Community Hospital
Forth Valley	Falkirk Community Hospital (Wards 1, 2 & 3)
	Forth Valley Royal (Ward 1)
	Stirling Community (Ward 4)
Grampian	Chalmers Hospital (GP Unit)
	Glen O'Dee Hospital (Morven)
	Inch War Memorial
	Inverurie Hospital (Doonbank)
	Jubilee Hospital (Rothieden)
	Leancoil Hospital
	Seafeld Hospital (GP Unit)
	Turner Memorial Hospital
	Woodend Hospital (Wards 15, 16, 17, links@woodend)
Greater Glasgow and Clyde	Lightburn Hospital (Wards 2 & 4)
Highland	Campbeltown Hospital (Acute Admission)
	Cowal Community Hospital (Admission Unit)
	Ian Charles Hospital
	Invergordon Hospital (Sutor)
	Mackinnon Memorial Hospital
	Mid Argyle Hospital (Glenaray)
	Portree Hospital (Marsco)
	Ross Memorial Hospital (General)
	Rothsay Victoria Hospital (General)
	Royal Northern Infirmary (Wards 1& 2)
	St Vincent's Hospital (Gynack)

Lanarkshire	Kello Hospital
	Stonehouse Hospital (Lochhart)
	Wester Moffat Hospital (Heather)
Lothian	Belhaven Hospital (Ward 2)
	Edington Cottage Hospital
	Liberton Hospital (Wards 1, 2, 3, & 4)
	Roodlands General Hospital (Ward 1a)
Tayside	Blairgowrie Cottage Hospital (GP Unit)
	Crieff Hospital (Ward 2)
	Montrose Royal Infirmary (Ward 1)
	Pitlochry Community (GP Unit)
	Royal Victoria Hospital Dundee (Ward 5,7 & 8)
	St Margaret's Hospital (GP Unit)
	Stracathro Hospital (Ward 2)
	Whitehills (Clova & Isla)



## **Appendix 2: Core national dementia learning resources to support workforce development in community hospitals**

### **Dementia Informed Practice level**

The Dementia Informed Practice Level provides the baseline knowledge and skills required by all workers in health and social services settings including a person's own home. Staff can gain the knowledge and skills to become informed about dementia by accessing the Informed about dementia: Improving Practice resource at:

<http://www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence/framework/informed-level/learning-resources.aspx>

### **Dementia Skilled Practice level**

The Dementia Skilled – Improving Practice Learning Resource is for people who work directly with people with dementia, their families and carers, and also for people who have substantial contact with people with dementia, their families and carers. It builds from the knowledge and skills presented in the Informed about Dementia: Improving Practice DVD.

This is a comprehensive learning resource with modules covering:

- Understanding Dementia.
- Promoting person and family centered and community connections.
- Promoting health and wellbeing.
- Meeting the needs of the person with dementia who is distressed.
- Supporting and protecting peoples' rights.

The resource can be accessed at

<http://www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence/framework/skilled-level/learning-resources.aspx>

Other key learning resources including further learning on:

- Supporting people with dementia in acute care
- Capacity and consent
- Supporting people with delirium
- Stress and distress in acute hospitals

are available at <http://www.knowledge.scot.nhs.uk/home/portals-and-topics/dementia-promoting-excellence/framework/skilled-level/learning-resources.aspx>





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