Enter & View Visit to Senior Health Wards at St George's Hospital

12 and 14 September 2017

Healthwatch Wandsworth

Acknowledgement

The Healthwatch Wandsworth Enter & View Team would like to thank the management, staff, patients, relatives and friends who made us welcome and assisted us in carrying out our visits and in preparing this report.

The Visiting Team

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healthwatch Wandsworth

Enter & View Visit to Senior Health Wards at St George's Hospital:

Executive summary

Background

The full report contains details of visits made in September 2017 by the Enter & View (E&V) team from Healthwatch Wandsworth (HWW) to three senior health wards at St George's Hospital, Tooting. St George's Hospital University Hospitals NHS Foundation Trust, which manages the hospital, was beginning to implement a new strategy to improve the inpatient care of older patients, in line with the 'Safe and Effective Care' strand of the its Quality Improvement Plan. Managers from the senior health service invited HWW to visit the inpatient wards in order to talk to patients and carers, to assess the current situation, and to learn more about the planned improvements. The E&V team had already decided that, in addition to looking at general standards of care for older people, it would focus on the care provided for patients affected by dementia whose experiences are often overlooked.

A 2016 report by the Care Quality Commission (CQC) found that the Medical Care service at St George's Hospital (which included the senior health wards) 'required improvement'. While acknowledging areas of good professional practice on the senior health wards, the CQC expressed major concerns about the unsuitability of 'the environment and supporting infrastructure' on some wards, which posed a risk to staff's ability to provide safe, high quality patient care. Dalby Ward was singled out as being an unsuitable environment for the care of older people, particularly those affected by dementia and delirium. Following the CQC report, the Trust made plans to upgrade and refurbish all the senior health wards, starting with Dalby Ward, which was closed to patients in June 2017.

Sources of information

HWW routinely prepares for its E&V visits by meeting with senior clinicians and ward managers, and where possible by site visits. Additionally in this case, the team spoke to staff in services which are available to provide advice and support to ward staff: the Dementia & Delirium team; the newly-expanded Old Age Liaison team (a sub-group of the Liaison Psychiatry team, employed by South West London & St George's Mental Health NHS Trust and based at St George's); and two part-time members of staff from the Alzheimer's Society who are able to provide information and support to relatives/carers of people affected by dementia.

The main aim of all E&V team ward visits is to obtain the views of patients and - where feasible - their regular visitors about their experience of care on a ward. In

this case, because of the large number of patients affected by dementia, delirium or other impairments of their mental capacity the team anticipated some difficulty in obtaining the usual volume of first-hand experiences from interviews alone. This meant that the team used observations of interactions and practice to supplement interviews. It is always our practice to observe activity and practice at mealtimes. To prepare for these visits, E&V team members (who in this case all had clinical backgrounds) received additional training from a CQC inspector, who provided guidance on the key features that make for acceptable and safe environments of care for people with dementia.

Ward visits

At the time of the Enter & View visits, the core of the senior health service at St George's was based in three wards:

Amyand (32 senior health beds). Patients here are normally expected to have a stay of 10 days or less. Patients tend to have better mobility and are more likely to be discharged home rather than to a residential care setting.

Heberden (24 senior health beds). This is the longest-standing senior health ward and tends to admit people with the most complex needs and high levels of distress. It has received a Quality Mark awarded by the Royal College of Psychiatrists for 'elder-friendly wards.'

Rodney Smith (28 beds, including 14 senior health beds). This ward took the senior health patients who were transferred from Dalby Ward. (The 10 ortho-geriatric beds previously on Dalby ward have been re-located elsewhere in the hospital). It now has 14 senior health patients, many of them with high-dependency nursing needs, and 14 beds for patients from the general medicine/diabetes service. Once the refurbishment of Dalby Ward is complete (in January 2018), it will be re-opened to take the patients from Rodney Smith ward, so that work can start on the latter.

Seven members of E&V team visited these wards for two days (12 and 14 September 2017). The core team organised itself into three smaller groups so that there would be all-day coverage to allow time for interviews and periods of observation. Mealtimes were observed on all three wards. Full interviews were completed with a total of 13 patients and 10 relatives/carers across the three wards.

The team agreed with the CQC's critical comments about the physical environments in Rodney Smith and Amyand wards. Members had not seen Dalby Ward before its closure, but welcomed the prompt action taken by the Trust to prioritise its refurbishment, to be followed by that of Rodney Smith, where the

current facilities have serious limitations. It was clear that all the wards were making an effort to make the wards more 'dementia-friendly', for example, by improved signage and illustrations.

Detailed reports from each of the wards can be found in Section 5 of the full report. These cover the main areas of 'overall experience of care'; the admission process; patient and carer involvement; staff attitudes and responsiveness; ward environment and facilities; support for dementia; meals and drinks; discharge planning; and the mix of patients on the ward. Analysis of the findings from each ward fed into the team's overall recommendations, as set out below.

Recommendations

Improving the quality of care

We saw a great deal of good practice, including strong leadership from the Matron Sharon Lynagh, and picked up several complimentary remarks about the care provided by ward nurses. However, we believe that more could be done to ensure that consistently high standards of care are met, including in the following areas:

- Ensure that patients do not develop new bedsores;
- Patients are helped appropriately with eating and drinking and that proper hygiene standards are maintained at mealtimes (e.g. no urine bottles on tables; handwashing for patients);
- Help patients to communicate their needs more effectively e.g. through the consistent use of pictorial menus;
- Prioritise the maintenance of patients' mobility levels at or above those they had on admission;
- Ensure that patients are treated with dignity and respect at all times and that they are as involved as much as they are able to be in decisions about their treatment and future;
- Increase the amount and quality of interaction between staff and patients through communication and conversation when providing care, observations and treatment;
- Pay more attention to patients' personal appearance to include hair-washing and hairdressing as appropriate;
- Pay more attention to the emotional needs of patients, including identifying signs of depression and, where appropriate, considering referral to the expanded older people's sub-team of the liaison psychiatry service;
- Address the need for patients to have meaningful ways to be occupied whilst in hospital (see in more detail below under ward environment and facilities). We share the view of the Alzheimer's Society that patients with dementia need

substantial support and stimulation from staff and carers to avoid the potentially detrimental effects of an unfamiliar hospital environment.

- We consider that the use of Reach Out or other similar documentation (to collect information about patients' backgrounds, needs and preferences) with all senior patients and their carers at the time of admission would greatly assist the personalisation of care and help to ensure consistently high standards of individualised care.
- We believe improved care in these and other areas should be supported by targeted training and supervision and peer review across wards.
- We invite the Trust managers to provide a view on whether current staffing resources are sufficient and appropriately deployed to achieve consistently high standards in all of these areas or whether changes in resourcing are needed to reduce pressure and improve consistency of care.

Patients with mental capacity

We became aware from the minority of patients on these wards who were without significant cognitive impairment that they can experience difficulty and discomfort on the senior health wards. We should therefore like to recommend that the Trust:

- Makes every effort to treat older patients with full mental capacity on general medical wards, if necessary by providing additional support to those wards.
- Ensure that on the senior wards those with mental capacity are treated appropriately as well as being fully involved in their treatment decisions, rather than assuming that carers need to fulfil this role.
- Consider whether the refurbishment of the senior health wards provides the service with an opportunity to address how the needs of those with greater mental capacity and physical frailty can best be met.

Carer involvement

We consider that standards of practice in relation to carers could also be improved in some areas:

- Consider whether there is a role for "carer champions" or "carer leads" among ward staff.
- Nurses and medical staff should ensure that carers and family members are regularly updated about the progress of their relative and that they are offered opportunities to raise questions and concerns on a regular basis.
- Ensure that each ward has a permanent, rather than rotating, discharge coordinator so that good and consistent practice can be developed;

- Ensure that the discharge coordinator role formally includes liaising with families so that carers and partners of patients are fully involved in all stages of the discharge process;
- Enact flexible visiting times for carers and close family members of all patients on senior health wards not just those with dementia or on the Butterfly Scheme and adjust the notices at the entrances to wards to reflect this;
- Ensure staff are aware of the Alzheimer Support worker role to support carers and signpost them in the community.

Written information

Whilst we recognise that most patients will not be able to use written information, we think that brief Information packs or leaflets should be prepared for each ward or for the three senior wards collectively. At a minimum these should outline what patients and carers can expect from a stay on these wards, give named contacts for carers and name of the Consultant, information about interpreting services and guidance about how to raise any concerns or make a complaint.

Ward environment and facilities

Finally, we have a number of specific recommendations in relation to the ward environment and facilities:

- When Amyand and Rodney Smith come to be refurbished, consider the scope for improving effective space standards as well as the application of dementia-friendly design.
- Specify that all shower rooms should in future be step-free wet rooms.
- Ensure that all call bells are working and within the reach of patients, especially in side rooms.
- Provide light-weight easily moveable chairs for visitors in each bay.
- All wards, once refurbished, should have a space for private conversations between carers and patients or carers and staff as well as for larger meetings.
- Introduce activities and stimulation which can be provided by the bedside as most patients are bed-bound and on Amyand Ward there is no dayroom on the ward.
- Routinely ensure that the access to the radio is activated for every patient as soon as possible after admission and provide headphones.
- Provide free access to TV and wifi for senior patients and their carers and encourage use of the TV for patients.

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The Full Report

1.0 Introduction

1.1 About Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) is the patient and public champion in the areas of health and social care services. At the national level, we send our reports to Healthwatch England. HWW is funded by the Department of Health through the local authority, Wandsworth Borough Council. Our staff and volunteers are managed by an independent local voluntary organisation, Wandsworth Care Alliance (WCA). HWW is governed by an Executive Committee consisting of four Trustees of WCA and four members directly elected by the community. Our activities are developed in consultation with the public at our Assembly meetings.

1.2 Enter & View

Healthwatch Wandsworth has the statutory authority to visit health or social care services provided in the borough, or which cater for the local population but are located outside the borough. We can observe how services are delivered. Our main aim is to talk to patients or clients, their close relatives or carers, and senior staff responsible for managing the services. Our main focus is on the service user's experience of care.

Our E&V volunteers receive full training, and are DBS (Disclosure & Barring Service) checked before they can become authorised visitors. After each visit, the team produces a report containing its findings and recommendations. The reports are then sent to the service provider for comment, and to relevant bodies such as Healthwatch England, the Care Quality Commission (CQC), and those responsible for commissioning and providing the service we have visited. Finally, our report and any response from the service provider to our recommendations are posted on the Healthwatch Wandsworth website.

1.3 Our E&V strategy

One of the main aims of our current E&V strategy is to collect feedback on the experience of patients of St. George's University Hospitals NHS Foundation Trust which is the main provider of acute care services in Wandsworth.

The Trust was inspected in 2016 by the Care Quality Commission (CQC) and their report of 1 November 2016[1] gave the Trust an overall rating of "requires

[1] The CQC report can be found at: http://www.cqc.org.uk/location/RJ701 This report followed an announced visit in June 2016 and an unannounced visit in July 2016.

improvement". Following our visit to renal services, it was suggested that we might be interested in focussing on services for older people. Since the E&V team has considerable experience of such services in residential and extra-care settings and also visited the older people's ward at South West London & St George's Mental Health NHS Trust in 2016, this was a welcome invitation.

2.0 Background

2.1 Description of senior health services at St George's Hospital

Senior health is the branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical, nursing and therapy skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home (The British Geriatrics Society, Compendium document 1.1, 2005 as cited on the St George's University Hospitals website).

The Senior Health service at St George's provides a comprehensive range of acute geriatric and rehabilitation services from St George's Hospital, Queen Mary's Hospital in Roehampton and St John's Therapy Centre in Battersea. These services currently include:

- Acute multidisciplinary inpatient service based on three wards on the St George's Hospital site, with a needs-related admissions policy
- Orthogeriatric input for fragility fracture patients >60 years and major trauma patients >70 years.
- Rehabilitation services on Mary Seacole Ward, Queen Mary's Hospital, Roehampton
- Outpatient clinics at St George's Hospital and the St John's Therapy Centre
- Day Hospital service at St John's Therapy Centre and Bryson Whyte Unit at Queen Mary's Hospital
- Domiciliary consultations

The visits covered by this report relate only to the three inpatient wards referred to in the first bullet point above, namely Heberden, Rodney Smith and Amyand wards. We did not examine any outpatient services, orthogeriatric care or the care of older patients in other parts of the hospital such as the cardiac, oncology or renal wards. The three wards take people mainly over the age of 65 but they

also admit some people under 65 who are very frail. In practice most patients on these wards are over the age of 75 and many are living with dementia.

2.1.1 Admission

Admission to the three senior health wards almost invariably follows an initial assessment carried out by the Older People Assessment and Liaison (OPAL) service. This includes a Geriatrician, an Occupational Therapist (OT) and a senior nurse and operates in the Clinical Decision Unit (CDU), part of the Emergency Department, or in Richmond Acute Medical Unit. Such assessments involve a multi-disciplinary approach to the care plan and any additional support needed in the community after discharge. This service currently operates Monday to Friday from 8:30 am to 5 pm. The Trust told us they would like to operate this service seven days a week but that would depend on the availability of community partners. The service helps liaison with community teams and is considered to have helped drive a reduction in the length of stays at the hospital.

2.1.2 The wards

The three senior health wards are managed by a single matron, Sharon Lynagh who reports to one of the Heads of Nursing. There are 38 general senior health beds in two wards: Heberden and Rodney Smith (which since the closure of Dalby Ward in June (see below) allocates 14 of its beds to older patients). In addition there are 32 acute senior health beds on Amyand Ward. These beds are mainly for very frail patients with limited mobility who are expected to have longer stays, often as they wait for housing arrangements to be sorted out. Staff on these wards are expected to have specialist training in working with patients with dementia and delirium with the skills to manage more challenging patients. There are a higher number of nurses to patients than usual.

Heberden Ward (3rd floor, Lanesborough Wing) is the longest standing senior health ward, where patients with the most complex needs and high levels of distress tend to be admitted. It has 24 beds in 4-bedded bays with two single side rooms and one two-bedded room. Heberden has achieved the "Quality Mark"[2] awarded by the Royal College of Psychiatrists for "Elder-friendly Wards". This involved a rigorous process of assessment with visits and questionnaires. The Quality Mark is awarded partly on the basis of the ward environment and Heberden is the only one of the senior health wards which currently meets this quality standard. It is more spacious in every way than Amyand and Rodney Smith Wards: the bays are very spacious and there is a door to each same-sex 4-bedded bay, the corridors are

[2] http://www.rcpsych.ac.uk/quality/qualityandaccreditation/elder-friendlyqualitymark.aspx

wider and there is much more storage space leading to less clutter with equipment in corridors. There is also a day room and a gym nearby. There are same-sex bathroom facilities with men at one end of the ward and women at the other.

Rodney Smith Ward (3rd floor St James' Wing) changed its function in June 2017 when Dalby Ward closed so that it now accepts 14 senior health patients. It also has 14 beds for patients with diabetes and endocrinological problems who are looked after by the same nursing team but have different medical input under a different consultant. The ward has a mixture of 6 and 8 bedded same-sex bays, two side rooms, same-sex bathrooms and a day room. Like Heberden Ward, many of the patients have dementia.

In addition, there are 32 acute senior health beds on Amyand Ward (3rd floor St James' Wing). These patients will normally be expected to have a shorter hospital stay (less than 10 days), they have better mobility and are more likely to go home. The criteria for admission to Amyand Ward exclude people with grade 3 pressure sores or where nursing home placement is required. The ward has a mixture of 4, 6 and 8 bedded same-sex bays with 2 side rooms. There are a number of single-sex bathrooms and toilets but the side rooms are en-suite. The ward has no day room, only shared use of the dayroom in an adjoining ward (Allingham). There is a shared gym for the third floor, mainly used by occupational therapists and physiotherapists for assessments or exercise treatment.

2.1.3 Staffing

Staffing on all three wards includes a Sister or Charge Nurse who works early shifts Monday to Fridays and is included in the numbers for qualified nursing staff for that shift. Most staff work long days but some work early or late shifts. In accordance with best practice, the same staff group work night shifts. Each ward has consultant medical staff (including junior doctors on rotation) who also have out-patient responsibilities and a variety of community commitments. Occupational Therapist(s) and Physiotherapist(s) are also part of the ward team. There is access to Dieticians and Speech and Language Therapists. As a result of a generous donation, a music therapist visits all three senior wards weekly.

Each ward also has its own discharge co-ordinator (at Band 6, working Monday to Friday) who works closely with services outside the hospital. Wandsworth Council Social Workers are based in the hospital and those for people from other boroughs come in as needed. Each ward also has a Ward Clerk, a Housekeeper and domestic staff.

The wards can also refer to the Liaison Psychiatry Team which has nurses and psychiatrists based at St George's and referrals can be made to the Mental Health Trust.

On Heberden Ward daytime staffing is five qualified nurses, including the Ward Sister, Louise Clancy, and six Health Care assistants (HCAs). Night-time staffing is three qualified nurses and three HCAs to allow for some 1:1 nursing. At the time of our visits there were 3 or 4 vacancies in the nursing staff. There is one OT and one Physiotherapist on the ward team. There are two Consultants on a rotational basis, allowing cross cover for the OPAL service and maternity leave (current cover provided by Dr Preston and Dr Sturley) supported by junior doctors.

On Rodney Smith daytime staffing is five qualified nurses, including the Ward Sister, Margaret Dunn, and four HCAs. Night-time staffing is four qualified nurses and three HCAs. If 1:1 care is required, extra staff are booked to provide this. At the time of our visits there were 1 Band 6, 3 vacancies at band 5 (qualified) and 4 at Band 2 (HCA). There is an OT and a Physiotherapist. Medical input is provided by one Consultant Geriatrician (Dr Mark Cottee) and junior doctors.

On Amyand daytime staffing is seven qualified nurses, including the Charge Nurse, Marlon Reyes, and four HCAs. Night-time staffing is five qualified nurses and three HCAs. Extra staff are booked if required. At the time of our visits there were 11 vacancies out of 25 posts at Band 5 (qualified). There are two OTs and two physiotherapists. Medical input is provided by two Consultant Geriatricians (Dr Chris Sin Chan and Dr Harold Lo. Dr Lo has input to Mary Seacole Ward and other responsibilities) and junior doctors.

2.1.4 Care planning

All patients are discussed by the multi-disciplinary team every day and there are nursing handovers between shifts. Care plans are printed with standard practice for each area of care but they can be personalised and tailored to each patient.

2.1.5 Dementia and delirium

Many patients who are admitted to these wards already have a diagnosis of dementia which is an umbrella term covering a range of progressive conditions involving damage or deterioration to a potentially wide range of brain functions. If dementia is suspected in a patient but not yet diagnosed, generally the diagnosis is not made during the in-patient stay. Instead, it is recommended that the patient is referred back by the GP for full assessment and diagnosis following discharge.

Some patients whether or not living with dementia may be suffering from delirium, an acute but normally temporary cognitive disorder which is due to a variety of medical conditions and usually disappears once the condition has been successfully treated. Delirium affects up to 30% of people in hospital and those over 75 are particularly at risk.

St George's has a team of three specialist (Band 6) dementia and delirium nurses (known as the DaD team) who guide and support the care of patients with these conditions throughout the hospital. They have developed pathways and protocols for the care of patients with dementia and delirium and provide specialist training and support for doctors, nurses and other staff in the senior health wards as well as elsewhere in the hospital. This includes familiarising staff with a customised assessment tool (4AT), so that they can monitor a patient's condition. However, the successful use of this tool depends on staff being able to recognise the signs of delirium and/or dementia. Providing training and support to Rodney Smith Ward has been a priority for the DaD team following its change of function.

They are overseen by the lead Consultant for Dementia and Delirium, Dr Jeremy Isaacs, Dr Joanna Preston, Consultant Geriatrician and assisted by a part-time Dementia support manager from the Alzheimers' Society.

As the CQC acknowledged in the report of their 2016 inspection, the hospital had developed a strategy to address the challenges posed in caring for older people with dementia and delirium. Its priorities have been reviewed since the CQC report. The Trust Dementia Strategy Group, chaired by Dr Isaacs, has co-ordinated this work. It reports to the Patient Experience Committee, and involves community groups such as the Alzheimer's Society and Wandsworth Carers Centre.

Dementia is a major theme in the Safe and Effective Care part of the Trust's Quality Improvement Plan. There are a number of objectives under this including:

- Taking part in the NHS John's campaign – developed after a nurse's relative, who was living with dementia, was admitted to hospital where the quality of care was such that he died shortly after getting home. The nurse felt that if she had been able have an input in his care during his hospital stay some of the issues could have been mitigated.
- One of the aims is to enable carers to stay the night and to be able to be on the wards through the day to be able to help with aspects of care. There are problems implementing this at St George's because of the physical environment as well as the need for operating procedures and safety considerations.
- Other elements of the strategy include:
  - Improving the dementia environment at St George's;
  - Dementia champions on the wards. This is part of the Quality Improvement Plan (QIP). Staff members at all levels on the 5 wards with the highest number of patients with a diagnosis of dementia (3 senior health wards and Richmond Ward at St George's and Mary Seacole Ward at Queen Mary's Hospital) champion the use of dementia passports and encourage feedback from carers via the dementia survey.

  - Wider use of the Butterfly scheme: a discreet butterfly symbol is used to identify patients in need of particular support because of dementia or delirium and this is accompanied by 'Reach Out to Me' paperwork documenting people's needs and interests;
  - More active use of the national survey of carers of patients with dementia. The five wards involved in the project get weekly emails with regards to the number of dementia passports and surveys completed. This informs the teams about which one is the 'ward of the week'.
  - A new project to recruit volunteers for the five wards mentioned above.
- There are also plans for development of dementia services in the community, which go beyond the scope of this report.

2.1.6 Relatives and carers

We were told that the Trust attaches great importance to good communication with relatives and carers. Consultants have time planned in to their job plans to attend family meetings. Discharge co-ordinators are heavily involved in family meetings. Consultants are based adjacent to the wards so they are more likely to be able to talk to visitors and patients. An Alzheimer's Society Support Worker visits on Fridays to offer support to patients and carers and provide a link to local Alzheimer Society support workers in each borough. Most of her referrals are currently from Heberden Ward.

St George's has just re-launched the Dementia Carer Passport. This is designed to help carers of people with dementia become more involved in care in the hospital and elsewhere by removing barriers such as visiting hours and providing more information about sources of support. There are currently no specific facilities for carers to stay overnight but carers can stay in side rooms with patients and funding will be applied for from the St George's Charity for chairs which can convert to beds.

2.2 Information about services for older people at St George's Hospital obtained from outside the Trust

2.2.1 The CQC report

The 2016 CQC report includes older people's care in the overall section on Medical Care. This service was rated as 'requires improvement', although the report acknowledges some areas of good practice:

• Practice was evidence-based and the service participated in a full range of national clinical audits. Results indicated good performance in relation to the majority of these.

• Patients were given information and explanations to enable them to understand the plans for their care and treatments and participate in their care.

Although the service faced challenges in the recruitment and retention of staff and this contributed to challenges in achieving and maintaining staff competency, action was being taken to mitigate the impact of this.

One of the CQC's major criticisms was that 'the environment and supporting infrastructure was unsuitable/unsafe and environmental issues on some wards impacted on staff's ability to protect patient's privacy and dignity.' This criticism is echoed in some of the report's specific references to the senior health wards chosen for Healthwatch Wandsworth's Enter and View visits.

With specific reference to care for people with dementia, the CQC noted the development of dementia and delirium pathways at the hospital, along with a proforma for the assessment of delirium and dementia and a care plan. Training for staff had begun and the initiative was being rolled out in a staged process. Medical wards were using the 'Butterfly Scheme' on their patient boards to identify patients affected by dementia and delirium. The CQC found that the use and completion of assessment and care plans was variable, with inconsistent completion of documentation.

Dalby Ward, one of the wards caring for people with dementia as well as older patients recovering from orthopaedic surgery, was singled out for some praise. Patients on Dalby Ward knew the ward manager (unlike people on many medical wards) and the report praised the supportive attitude to patients and staff. Staff on Dalby Ward were 'very dementia focused' and had a good knowledge of the condition. However, the ward was not modernised, and there were several issues which had the potential to impact on patient safety.

In light of the CQC inspection the Trust recognised that the environment on Dalby Ward as it stood was not appropriate for dementia and care of older people. It was not considered possible to upgrade the environment whilst the ward was in use, so it was decided to close the ward on 18 June 2017 pending refurbishment. The overall plan is to upgrade and refurbish all of the senior wards to at least minimum standards for dementia care. Dalby Ward is to be refurbished first, although not necessarily up to the full specification, and used as a decant ward to hold patients whilst the Trust upgrades the other ward environments. There will be 3-bedded bays with a bathroom in each bay, a quiet room and a space where patients can eat together. It is hoped that Dalby will be finished by the last week of January 2018, and Rodney Smith remains the priority ward to move to Dalby and then be upgraded. The rest of the refurbishment programme will be planned around the biggest risk. Funding has been allocated to enable the first stage of this

programme. A parallel programme involving upgrading bathrooms is going ahead and will not require ward closures or patient moves. It is expected that it will take between 12 and 18 months for the Senior Health service to become fully settled.

2.2.2 Information from the Alzheimer's Society

Two members of the team had a meeting on 1 September 2017 with Nicola Zimmerman, Dementia Support Manager, and Amandeep Virdee, Dementia Support Worker, from the Alzheimer's Society. They gave us a variety of useful background information which is incorporated into Section 2.1 above. In addition they made a number of observations about standards of care:

- In general they considered that St George's compares well with other South West London hospitals with which they work. Carers they speak to at St George's are happy with the care given to patients

- The use of agency nurses on the wards can sometimes lead to poorer practice with patients affected by dementia and delirium.

- The training courses provided by the DaD team were good, and well-attended, although it was difficult to check on how well lessons were being put into practice. There was a sense that some ward nurses were too ready to contact the DaD team for help, despite having been trained on how to deal with the problem.

- There was a sense that, out of the three wards we visited, Rodney Smith Ward had faced the greatest challenge immediately after the closure of Dalby ward, due to the changed patient mix.

2.2.3 Information from South West London and St George's Mental Health Trust

On 14 September, during our visit to the wards, two members of the team met with Bethan Moseley, Old Age Liaison Nurse Specialist in the Liaison Psychiatry team employed by South West London and St George's Mental Health NHS Trust based at St George's. This team which provides 24-hour coverage has recently been enlarged to include a sub-team for older people. Bethan attends the meetings of the Dementia and Delirium Strategy Group, and DaD team meetings at which difficult or complex cases are discussed, as well as liaising with the DaD nurses on the wards.

The main emphasis of Bethan's work is on providing continuity of mental health care across team boundaries. The team receives referrals relating to older patients from all parts of the hospital. The three main conditions that the old age sub-team has to deal with are: dementia, delirium and depression and this also includes

cases of deliberate self-harm. They also provide advice about people with drug and alcohol problems and assess people with alcohol-related impairments. Following assessment and review of medication patients may, where appropriate, be referred to Springfield Hospital (South West London and St George's Mental Health Trust) but many are referred back to their GP with advice.

In relation to the three senior health wards, most referrals come from Heberden Ward. Bethan praised the 'holistic' approach to care on the ward, and thought that the staff were compassionate and 'enjoyed their patients'. Amyand Ward was also good for making appropriate referrals to her team. No referrals had yet been received from Rodney Smith Ward since it changed its function to providing care for older people (and Dalby had also referred few patients). One problem on the wards was the lack of private space to talk to people. Bethan also believed that there is still a lack of awareness about delirium at St George's Hospital as compared with a similar London hospital, where there are more geriatricians on the staff.

In response to a Freedom of Information Request, the mental health Trust disclosed that in the financial year 2016/17 (before the establishment of extra posts for older people) there had been 2459 referrals to the Liaison Team with 298 of these being for patients over 65 years (12.1%). Of these 298, a total of 51 then had contact with the mental health services for seven days or more. There was no information about the number of referrals from individual wards.

3.0 Preparing for our visits

3.1 Meetings with senior managers and clinicians at St George's to discuss services for older people

On 12 July 2017 four representatives from HWW met the Deputy Chief Nurse, Robert Bleasdale; the Consultant Neurologist and Dementia Clinical Lead, Dr Jeremy Isaacs; the Head of Nursing for Specialist Medicine and Senior Health, Tessa Longney; and the matron for the senior health wards, Sharon Lynagh. We were given a comprehensive overview of the current services for older people at St George's, as well as future plans. These include significant development and expansion of community-based services, which go beyond the scope of this report. Information provided at this meeting has been incorporated in Section 2.1 above.

The senior managers told us that the importance of good dementia care was now more widely recognised by senior Trust management. It was now important to ensure that initiatives such as the assessment and care plan proformas and the Butterfly Scheme were being implemented consistently by staff across the medical care service. However, the strategy faced some significant challenges: financial

constraints, the poor condition of many wards; difficulties with retaining staff, in particular nurses (this was a Trust-wide issue), and the resources required to train staff across the Trust about documentation and helping them to embed the right culture.

On 31 August 2017, five members of the visiting team met Sharon Lynagh, matron for the senior health wards, to prepare in more detail for our visits. Sharon gave us a great deal of information which is incorporated in Section 2.1 above and led us on a brief walk around the three wards, introducing us to two of the ward managers. We agreed to carry out our Enter and View visits on 12 and 14 September and to send Sharon posters and leaflets beforehand to alert patients and relatives to our visits.

On 14 September during our visit to the wards two members of the team met with Dr Jo Preston, Consultant Geriatrician mainly to discuss the DaD team. This information has been incorporated above.

3.2 Planning and methods including objectives of our visits

In planning our visits to the three senior health wards at St George's we agreed that our main aims were to:

- Observe patients and staff and their surroundings.
- Capture the experience of patients, relatives and visitors and any ideas they might have for improvement.
- Identify examples of good working practice.
- In particular, assess the attitude of all staff towards older people and the quality of their communication with them.
- Assess the awareness and use of the Butterfly Scheme and other measures to support people with dementia and delirium across the three wards by patients, carers and staff.

Before the visits, we decided on some key topics and interview prompts to use. Although we ask specific questions, we also give plenty of room for people to comment on other issues and to elaborate their answers. We also agreed on a list of specific issues to observe on each visit.

In reporting findings, we strive to maintain confidentiality and anonymity and so the gender-neutral pronouns “they” and “their” are used throughout and some very identifiable comments have not been used.

3.3 Training

Although most members of the visiting team have considerable experience of visiting services for older people (including those for people with dementia) and some have worked in services in the past, as part of the preparation for these visits, all members of the team undertook on 6 September 2017 a morning's Dementia Awareness Training. We found this training, kindly offered by Jon Fry from the CQC, very useful.

4.0 Our Visits

4.1 Heberden Ward

On 12th September four members of the team visited Heberden Ward in the morning and three in the afternoon. One member of the team returned briefly on 14th September. We were greeted by the Matron, Sharon Lynagh and Liza Rodrigueza, Junior Sister (as Louise Clancy the Sister was on annual leave). Our leaflet was on the entrance door to the ward. All 24 beds on the ward were occupied. Although there were several discharges in the pipeline and some were overdue we were told that discharges were often delayed.

There were four qualified staff and seven HCAs on duty, one of whom was a newly qualified nurse, not yet registered with the Nursing and Midwifery Council (NMC), and another of whom was from the staff bank. There should have been five qualified staff but the newly qualified member of staff had to be counted as an HCA.

We were told that seven patients had mental capacity. We spoke to all seven of these patients for varying lengths of time and had a brief chat to one additional patient. We spoke to four carers, all in interviews separate from those with the patients. Three of these were carers for people we had interviewed and one was a carer for someone not interviewed. Thus we have information in relation to nine patients: five women and four men, aged from their mid-60s to late 90s. Seven were White British, one was White European and one Afro-Caribbean. One had been admitted the day before, five had been on the ward for two weeks or less, one for three weeks and two for more than a month.

We spent time observing the ward environment and functioning and two members of our team also observed the serving of lunch and one observed supper. Part of the lunch session was also observed on the second visit on 14th September.

4.2 Rodney Smith Ward

Two members of the team visited the ward during the morning and afternoon of the 14th September and this included observing lunchtime. Our report is based mainly on observations and interviews with just one patient and two carers. The majority of the senior health patients were living with dementia and lacked mental capacity.

All 28 beds were occupied: thirteen of the patients were under the care of the senior health care team and were scattered across the bays rather than being grouped together. We were told that the other patients on the ward were as highly dependent as the senior health patients.

The ages of the senior patients we saw were in their 80s and 90s. The patient we interviewed was White British as was one of the carers; the other carer was Black British.

We were given an introductory talk and were shown around the ward and all areas by the senior staff nurse in charge that day, Band 6, Jeanette Juquilon. We were told that nursing team was short of one trained nurse that day shift. The Sister, Margaret Dunn was working in her office on the ward on a "management day" organising the staff rota for the coming month amongst other duties. We were told that two trained nurses and four healthcare assistants at band 2 had been transferred to the ward from Dalby to add to the nursing establishment of Rodney Smith Ward. All staff on the ward have had an hour's training with regards to patients with dementia and delirum provided by the DaD team. There was further training planned in October 2017. There is funding for six places for the Dementia in Practice Course run by Kingston University which has been shared between the 3 senior heath wards over the next academic year. The DaD team continue to visit Rodney Smith Ward to support staff.

At the end of our visit, the ward Sister expressed her disappointment in the level of staffing allocated for the day shift following the change in function. She also expressed her concern and dismay that there had been a small number of patients who had developed pressure sores after being admitted onto the ward. Other staff mentioned challenges on the ward, including the discharge process, helping carers to understand the process of palliative care and encouraging mobility of patients who had previously been independent and mobile prior to their admission. The physiotherapist, occupational therapist and nurses were all involved in this care. The patient's mobility is assessed by the whole Multidisciplinary Team.

4.3 Amyand Ward

On 12 September, 4 members of the team visited Amyand Ward at various times between 12.30 pm and 6 pm. On arrival we were welcomed by Marlon Reyes, the Charge Nurse. We saw our leaflet pinned to the front of the desk at the nurses' station. We were told that the ward was full (32 patients) with 3 discharges and 3 admissions expected during the day. In the event, one of the discharges had to be cancelled because of the late arrival of transport to a nursing home: this meant that the corresponding admission had to be delayed and the incoming patient presumably spent the night in the Acute Medical Unit (AMU). We were told that the day shift was up to full strength and that one extra nurse had been booked to escort a patient to an appointment outside the ward. The consultants had been round the ward earlier but 3 more junior doctors were on duty. We were told that the majority of patients would have difficulty giving us feedback but 6 patients were identified as likely to be able to help us. One of these was feeling tired and declined our offer to talk. We managed to speak to 3 male and 2 female patients aged between 71 and 89 in varying degrees of detail. Of these 3 were White British, one West Indian and one Asian. Three of the patients had been on the ward for less than 5 days, while the other two had been there 2 or 3 weeks. We also spoke to 3 relatives or carers of patients who were visiting. We spent some time observing the ward environment and operation and two of us observed the serving of the evening meal.

On 14 September another member of the team visited Amyand Ward in the late morning and during lunchtime, carried out further observation and interviewed more fully one of the patients spoken to on 12 September as well as the carer of another patient. Staffing was at similar levels as before except that there was an extra HCA to provide 1:1 care for a patient who had been newly admitted.

5.0 Our Findings

On Heberden and Rodney Smith Wards all of the patients were very frail with multiple problems including bedsores, poor mobility, stroke, poor food intake and cancer. Only one of those we spoke to was independently mobile and most were in bed in hospital gowns. On Amyand Ward there was a similarly wide range of conditions and although patients were unlikely to have a long stay many were frail and most were currently very unwell. Many had some degree of confusion on admission and for some this still remained although they did not have a diagnosis of dementia. This means that information, especially factual information, cannot be taken to be totally reliable. We are somewhat more confident about the accuracy of how patients felt about the way that their care has been provided. However, we have supplemented the direct information from interviews by our own observations and with the information from patients' carers. Whilst we have

not observed personal care we have observed mealtimes and spent time observing staff responsiveness and interactions. We have used the term “confused” to refer to patients when we did not know whether they had a diagnosis of dementia or delirium as part of their presenting problems.

We noted that the TV and wifi facilities for patients and visitors had to be paid for. Apparently there is a period of two hours when TV could be watched free but we did not notice any patients watching TV. Radio has to be activated and we were told that nurses did this for patients who were not able to do it for themselves. Again, we did not notice any patients listening to the radio. One carer we spoke to was unaware that TV could be accessed at all and the nurses said that it was rare for anyone to want it.

Subsidised parking is available for in-patients on a daily or weekly rate. There is a form to fill in and the ward budget meets the additional parking charges. Anyone with a Blue Badge can park free.

Each of the wards has noticeboards, both inside and outside the ward, with a great deal of useful and generally well-presented information. There are some pictures in the corridors but none in bed bays apart from the noticeboards.

The white boards above patients’ beds were small and the information about the nurse and HCA providing care for the day was often not very clearly written and in one case was missing. Some boards had the butterfly symbol but some patients on the scheme did not have the symbol on their board. On Amyand Ward there was additional information about each patient’s need for hearing aids and glasses. These boards were not visible to any patient who was bed-bound as they were behind them.

Close to the nursing station on Amyand and Rodney Smith Wards we saw a Sound Ear machine (shaped like an ear) which is used to alert staff to the level of noise on a continuous basis using a green, yellow, red (traffic light) system lighting up different parts of the ear. This was connected to a computer. When we arrived on Rodney Smith Ward we pointed out that it was not plugged in.

5.1 Heberden Ward

5.1.1 Overall quality of care

Most patients were happy with the care that they were receiving and had very favourable things to say about both nursing and medical staff. They generally thought that they worked well as a team although there were occasional communication issues. Carers were a little less positive and were able to give more

detail about things that concerned them and we thought that whilst they had more detailed recollections of events, they were also not on the ward all of the time.

5.1.2 Admission

None of those interviewed were newly admitted. Five people had transferred to Heberden from the AMU in three days or less and one in 5 days. Those who had been in the hospital longer before transfer to the ward had generally been on other wards than the AMU before transfer. Several had had more than one admission in the past few months.

Most patients were relatively happy with their process of admission, but some described it as long. However, two of the carers' recollections were more specific and much less positive. The AMU was described by one as "chaotic" with the patient being left in soiled clothing until the carer requested an intervention and they were not satisfied with the way that this was handled. Another said that a fracture was not properly documented so the patient was incorrectly lifted. Although we have not visited the AMU, we think that we should record these carers' comments as they stand.

5.1.3 Patient and carer involvement

We asked patients and carers about whether they felt involved in their care, including whether the care plan had been explained, whether they felt able to raise any concerns about their care, including make a complaint and whether they had had been asked for feedback. We noted that there is a great deal of information displayed on posters including a poster saying "don't take your troubles home with you" with pictures of the Ward Manager and Matron. However, patients and carers were not given a ward information pack and we wondered how easy it would be for patients who were mainly bedbound, and for carers to see and absorb all of this information.

Few patients had any awareness of a care plan and only one said that they felt explicitly involved. One spoke of lack of continuity with different doctors, another of lack of continuity between wards. Some carers had had to request meetings to learn about the plan of care and were in several cases very concerned about discharge plans. On the other hand, one patient said that they saw the doctor almost every day. Another said that the care plan was "very vague" but was clear about progress that was needed before discharge.

The most prominent issue for carers was patients' loss of mobility and the implications that this would have for care following discharge. Three carers said that significant degrees of mobility had been lost since admission and that not enough was being done to keep patients mobile. One carer said: "The nurses are

OK but they don't give any encouragement to walk, even for 10 minutes. They send physios now and then" but the carer thinks that they "see [the relative] as a lost case". This affected discharge plans and for some was leading to placement in a care home. For other people, carers were very concerned about how care would be managed at home. On the other hand, one rather frail patient said that they thought that "they want me to do exercises… they probably want to clear the ward … but I'm not in a terrible hurry [to leave]."

Visiting times seemed to be very flexible and it was clear that this was not just for patients on the Butterfly Scheme.

Although the Alzheimer Society support worker receives referrals from Heberden Ward we identified one carer who would benefit from support who was happy for us to mention this to staff. They had apparently not been referred because staff did not think it relevant despite the diagnosis of dementia.

Some patients and carers had issues about care and about discharge which they had not managed to discuss with staff. We were given permission to discuss two issues with staff and another concern had been resolved by chance. Other patients did not want their concerns fed back.

5.1.4 Staff

We asked about staff attitudes to providing care and whether patients and carers thought that the patients were receiving the help that they needed. We also asked about whether staff had time to talk to them and whether they were responsive to call bells and requests for help, whether patients knew who was caring for them and whether staff introduced themselves each day or shift.

Nursing staff

Almost all patients and carers were very positive about the attitude of nursing staff and the help that they gave to them or their relative. Everyone we spoke with said that their privacy and dignity was respected. Everyone needed help with at least some aspects of personal care and some patients had all of their care provided in bed. Staff were perceived to be very busy and that they did not have much time to talk apart from providing care. Teamwork was generally praised: "[they] work really well together", however one patient mentioned a lack of communication between wards and a carer told us about being asked to come in to sign a consent form which then turned out not to be necessary. They blamed this on poor communication but generally thought that "the doctors and nurses are marvellous".

Positive quotes included: “the nurses and matron are superb”, “They are very busy, but very kind”. Another described how on admission they had missed a meal and staff went out of their way to find out what they would like to eat and to provide it. “The nurses are very caring”.

However, there were a few less positive comments which included: “they try … they vary … one or two are a bit rough… some of them are very helpful”. [In relation to a question about caring attitude] “I guess so - they vary in their ability to show it. A few sometimes are lacking in attention.”

The patients with most reliable memory said that staff introduced themselves. Others said that they did not but that this did not matter to them.

Staff responsiveness

We understood from Sharon Lynagh that there was a policy of proactively seeking whether people needed any help or had any unmet needs. We did not see this systematically in operation however one patient mentioned this to us as an example of staff ensuring that their needs were met. On several occasions we saw HCAs sitting in a chair in a bay near the door and observing patients. We did not see staff talking to patients except when they were providing care of some sort nor did we see staff walking with patients, except those who were disturbed. On our first visit there were three people who were wandering, somewhat distressed, and at times approaching us asking to leave the ward to go home or find someone they believed needed them (e.g. to see a child who is now an adult). Staff attempted, mostly successfully, to take them away from the door and talk kindly to them to help them to become calmer. Two of these patients recurrently tried to leave or asked us if they could leave. We did not see any evidence of activities being provided to distract or engage them apart from talking to them.

On our second visit the ward was quieter with fewer patients wandering or appearing in the corridors distressed. However, there were two people in one bay who appeared distressed and looking for help: one was calling out and the other was moaning. Staff did not come spontaneously but were alerted by a visitor. The response to being told about the patient moaning was “[the patient] is always like that”.

Staff responsiveness to call bells was variable with some patients saying that staff came quickly or as quickly as they are able to, given how busy they are. Two patients we saw could not reach their call bells and others were unsure where they were. One of the patients who could not reach their bell was calling out for a nurse when our volunteer arrived, but no one came in response to this. The volunteer was able to deal with their request to have the table with drink within reach.

It was difficult to ascertain how responsive staff were to patients' changing needs except that on the one hand patients told us that they were happy with the care that they were being offered but, on the other hand, carers' raised concerns about loss of mobility. One family were concerned that a new bedsore had not been picked up by staff.

Other members of the ward team

Most patients said that they were seen quite frequently by doctors and although there were often different doctors this did not concern them. They introduced themselves and privacy and dignity were respected. One carer remarked that doctors often only came to see one person in a bay and that other patients were upset by this. One patient said that doctors often said contradictory things.

Reports about physiotherapists and OTs were mixed. One patient told us that they had had daily exercises for a time and a suggestion of using the gym but that this had not happened. The same patient said "physios take over, running people's lives, I don't feel listened to". This was especially because their relative had been contacted by a physiotherapist or OT when the patient was fully capable of being involved in their own care decisions and when they had asked for their relative not to be contacted at work. Another patient was pleased with daily bed exercises with a physiotherapist.

One patient who needed something to be done with a toenail said that they had been told that there was only one chiropodist for the hospital. We have since been told that there is a lead chiropodist for the trust and this person manages a small team who will provide the care and treatment as required.

5.1.5 Ward environment and facilities

The ward is bright and has a spacious corridor with a handrail running along the length at waist height. There are doors into five 4 bedded single-sex bays and a two-bedded bay and two single rooms, making up 24 beds in all. Although the bed-spaces were quite spacious, there was often no chair for a visitor by the bed although there was a chair at the entrance to each bay that seemed to be used by HCAs for observing the bay as a whole.

All of the bathroom and toilet facilities looked old-fashioned and rather tired-looking. One toilet was in a large room with only a hair-washing sink in there as well, although there would be room for a wet-room style shower. Some were labelled as single-sex. We noticed that only one of the showers was wet-room style and the other had a lipped shower tray meaning that these could not be used exclusively as single-sex facilities for those with physical disabilities.

When we were visiting we saw the large day room being used for meetings. It has large round tables and chairs with lockable wheels but there were no materials for activities. There is a whiteboard with information about patients and this is covered with a roller blind to ensure confidentiality. A large flatscreen TV, which will in the future be used as an electronic whiteboard, is not currently in use. The décor was quite bland with some framed abstract pictures on the walls. Although it would be possible for patients to use the room the only evidence we saw of this was people being taken there for meetings about discharge (when a person was taken there in her bed) and a birthday party where a large family group was assembled.

We did not see any evidence of activities or books being made available to patients. For the most part, patients sat or lay in bed and were not occupied in any way. A few patients were seated in chairs, one or two with their own magazines or books. Most patients were wearing hospital gowns and only one or two were wearing their own pyjamas or clothes. Many people did not seem to have had their hair brushed. A lot of people were asleep for much of the day and only a few were sitting in chairs beside their beds at any point in the day. The number of people having a sleep increased just after lunch although there was no formal rest period. One patient's gown had come adrift so that their underwear and an incontinence pad were visible.

The ward was generally calm but in the morning it was busy with doctors doing ward rounds. As already mentioned, there were two or three patients who were very confused who wanted to leave the ward and who were distressed at not being able to go home.

We asked patients about whether beds and chairs were comfortable and adjustable, about the temperature on the ward, about noise at night, about cleanliness and about food. Several patients we spoke to had pressure sores and consequently were not very comfortable even with the provision of special cushions, pressure relief mattresses and cream. A couple of patients said that the ward was too hot and one had a fan. Those seen in single or double rooms found the temperature more acceptable.

Several patients said that there could be a lot of noise and disturbance at night. One patient said that they accepted that it was a "geriatric ward" where patients can be difficult and that staff "[have to] do an impossible job at night". One felt that they [the patients] "had to put up with it", another said that the patient opposite shouted out a lot and had told a relative that this patient came over to their bed. They said they could "ask the staff for sleeping pills".

Everyone said that the ward was kept very clean and those who used the bathrooms said that these facilities were also clean.

5.1.6 Support for dementia

The ward had been set up to be dementia friendly with doors to bed bays painted blue, those to toilet and bathrooms painted yellow and doors to offices, the sluice and other non-patient areas painted white. In addition, there were laminated signs with pictures and words for the shower and toilet facilities.

The Butterfly Scheme is in use for patients with a diagnosis of dementia who are prepared to be included. We saw the symbol on the white boards for some patients who were on the scheme but not for others. Most of the patients we spoke to did not have a formal diagnosis of dementia and only one was on the Butterfly Scheme so we could not easily assess how well it was working.

The red tray system is in use with different levels of support being provided depending on need. This is discussed below in section 5.1.8. Far more patients have red trays than are on the Butterfly Scheme as would be expected as there may be a wide range of reasons why patients need help, encouragement or monitoring in relation to eating and drinking.

The ward is able to refer patients and carers to the Alzheimer's Society support worker who comes to the ward on Fridays. Although the support worker reported receiving a number of referrals from Heberden, we think that there is scope for more based on the feedback from one carer (see above, section 5.1.3).

5.1.7 Meals and drinks

There is a policy of protected mealtimes to encourage patients to eat better without interruptions or distractions. This applies to professionals visiting. Carers who can help their relative to eat are encouraged to be there at mealtimes and evidently help staff by providing prompting, supervision and sometimes physical help, leaving staff freer to help other patients. There is also a red tray scheme in operation to indicate people who need some degree of help or observation in relation to eating and drinking.

All of the patients and carers we spoke to had views about meals. Their views about the food were very mixed with some patients praising the range of choice and the quality ("like a hotel") and others saying that it was bland ("no taste") or that there was not enough choice. However, a patient with diabetes found the puddings too sweet and did not know if there were diabetic options on the menu. We observed that another patient, who had been offered a special menu, asked

the person who came to take the evening meal order which meal had the highest protein content and the person did not seem to be able to answer this.

A lot of the patients needed help and/or supervision at mealtimes because of concerns about their nutrition. Some carers mentioned that patients had lost weight or had a poor appetite and acknowledged the staff's positive role in encouraging them to eat. Staff resources were stretched at mealtimes and sometimes people were not prompted at the right point in their meal so food from a main course was left uneaten because they had already moved on to their dessert by the time a staff member was free to help. We saw some examples of good practice with patients being encouraged to eat and told what the food was. On the other hand, we also saw several occasions where staff stood rather than sat by patients and where patients were asked questions that they were probably unable to answer e.g. "do you want any help?" On a couple of occasions two members of staff were attending to the same patient and asking questions. A poster in the corridor gave very good information about how staff should offer help with eating but this did not seem to be followed in many cases.

Other things that we noticed at mealtimes: all patients were served with squash whereas water jugs seemed to be left full on the tables; patients were sometimes not positioned well enough to be comfortable eating; the meal (turkey and mashed potato) looked pallid and unappetising. It was challenging for staff that some patients were asleep when the meal arrived and it was difficult to rouse them. At least one meal by a person who was sleeping was largely uneaten, with no staff member present, at supper time by the time we left.

5.1.8 Discharge planning

Patients and carers were unclear about plans for discharge and, in some cases they were very concerned about premature discharge or lack of adequate provision at home upon discharge. One person had been readmitted a short time after a previous discharge and put this down to the previous discharge having been premature. A couple of patients and carers mentioned being involved in discharge planning either in discussion with the ward sister or by learning that there would be assessments of how well carers could cope.

In the afternoon of our visit we observed therapy staff bringing equipment for a patient to try prior to going home, and liaising with some relatives. On our second visit the Discharge Coordinator explained that the discharge coordinator post on Heberden is filled on a rotational basis as apparently no one wants this as a permanent role.

We were told that there was a significant number of delayed discharges for a wide range of reasons, but particularly delays in putting appropriate care packages in place.

5.1.9 Mix of patients on the ward

We understood from our meetings before our visits that patients were admitted to the ward where their needs could best be met. However, some patients' and carers' perceptions differed from those of the professionals admitting them. Four patients and/or their carers queried whether Heberden Ward was the most appropriate place for them to have been admitted to. Three patients with no evident cognitive impairment told us that did not think that they belonged on a ward with so many people with cognitive impairment and the family of one patient was vociferous about how patients with "mental health problems" or dementia should not be on the same ward (and certainly not in the same bed bay) as patients who did not have such problems. They and another patient said that because of problems like shouting and swearing it was not a place where their grandchildren could visit them. All of these patients and carers found it distressing that people who were confused were calling out and would sometimes come and disturb them at night. One patient had started to take sleeping pills to deal with this.

One carer in particular said that their relative, who had been admitted to the ward because of significant physical needs, was treated like a "dementia patient" although they did not have cognitive impairment. The patient was wearing incontinence pads when they were able to indicate that they needed the toilet. This was perceived as being for the convenience of staff.

Dr Jo Preston, discussing the refurbishment of wards, said to us that any facilities or signage which is helpful for patients with dementia will not be in any way detrimental to other patients and many of the patients on Heberden Ward have a significant degree of cognitive impairment. However, in our view, although environmental support for people with dementia, such as signage, will not be detrimental to other patients, it is crucial that care is tailored to each individual patient's needs.

5.2 Rodney Smith Ward

5.2.1 Overall quality of care

We spoke to too few patients to get a clear reading of their views of the overall quality of care. However, there was an overall feel of a very busy ward environment with a lot of multidisciplinary staff on the ward round. Staff moved quickly but quietly around the ward to attend to different needs. We were

impressed by the team work seen on the ward by all staff around the serving of meals.

5.2.2 Admission

The patient and two carers we spoke to had all experienced emergency admission via A&E. The admission process was not identified as a problem by the patient or carers. One carer said that there had been good clear information about the patient's diagnosis, but no information about the ward.

5.2.3 Patient and carer involvement

One of the purposes of our visit was to establish if both patient and carer felt involved in their care, whether they had been informed of their care plan and if they had been asked for feedback about their care.

The patient that we spoke to had been in the ward for just over a month but had not been asked for feedback. The patient was unclear about a care plan having no specific date for discharge and expressed uncertainty about the diagnosis. There was assurance from the patient that the carer would know how to raise any matters of concerns. The patient did not know who the ward manager was stating there had not had any contact from her and said there had not been any contact with a consultant.

One carer who had a lot of concerns around their relative's frequent admissions and home discharge had not had any contact from any staff during this admission (although they had been asked for feedback on a previous occasion when the relative was in St George's). Although staff told us that they were flexible about the visiting times this carer was unaware of the Dementia Passport or of flexibility of visiting hours, despite being a regular visitor with a long journey. A medical student who was attending to the relative overheard our conversation and offered to contact a doctor to meet this carer. We fed back our concern to the nurse in charge at the end of our visit.

Another carer we spoke to had been told "different things by different people" but had been offered very flexible visiting times by the staff. The same carer felt "quite happy to talk to any staff member" to raise any concerns.

5.2.4 Staff

We aimed to find out about the attitude, behaviour and responsiveness of ward staff, which seemed to us to be a key element in the quality of care.

A carer we spoke to said that the "staff are all lovely and there seems plenty of staff" but said that there "should be more one to one attention for patients as

although the patient can become very agitated it is possible to calm with attention". They said that patients are generally treated with dignity and respect by staff. However, the patient we interviewed said that staff do not "always" close the curtains around the bed to promote dignity and respect for privacy.

We observed staff being responsive to patients' requests in a caring and sympathetic manner and the tone of their voices was comforting, showing patience. On the other hand, when staff were carrying out routine nursing tasks, we did not observe much interaction or explanation. For example, there was a patient being transferred from the bedside chair to bed with the curtains drawn but we heard minimal verbal interaction from the nurse to the patient.

It is clearly a challenge maintaining patients' personal hygiene and appearance and this can impact on feelings of wellbeing. How this is managed is clearly patchy. For example we were told about a female patient having her hair cut by nurses, whereas the male patient we saw had long unwashed and unkempt hair and welcomed our offer to feedback to staff that he would like help with this. There is no hairdressing service available to patients.

We did not notice staff providing opportunities for stimulation and activity on the ward. The patient that we interviewed, although articulate once engaged, had "no interest" in listening to the radio and admitted to "feeling low" in mood. The patient, had no type of stimulation at all, was isolated after an extended period of hospitalisation, with only a relative who lived at a distance visiting and it seemed that the patient had insufficient attention to emotional and mental health. With the patient's permission we fed back to the nurse in charge at the end of our visit regarding a referral to the Old Age Liaison Nurse Specialist of the Psychiatry team based at St George's and she seemed not to have considered this. This fits with what we had heard about the service not having received any referrals from this ward.

5.2.5 Ward environment and facilities

The following are our observations as none were given by patients or carers.

Although the ward looked clean, the environment was generally cramped, particularly the ward corridor which was full of a variety of trolleys and other equipment. If a patient or staff member is walking up and down there is only space for one person or a patient in a wheelchair or bed. In the bays, the beds are very close to each other allowing little or no privacy.

The toilet and bathroom facilities (single sex) were of a poor standard and in need of urgent upgrading. The bathroom had a bath set in the middle of the floor and would require a patient with good mobility or staff lifting equipment to be able to

access the high sided bath. The small shower room had a step into the shower that would be a risk for falls and trips and would be particularly confusing for those with dementia and sensory loss. We were told that patients can use the wet room on Amyand Ward but this requires additional organisation, time and resources from nursing staff to take a patient across to another ward. We did not have any details of how often the wet room is used.

The day room at the end of the ward is small and used as a storage facility for lifting and other equipment. It is not a very congenial environment; it felt unwelcoming and has a few chairs in a row. It was not decorated to an acceptable standard; there was no type of activity available in the very limited and cramped space available. The senior health patients were immobile and spent the majority of the time in bed so would require stimulation near to their bedside to be able to benefit from any activity.

We understand that the day room is used to discuss discharge planning with relatives and patients. There was a meeting in progress with a social worker and a relative during our visit. There were no other rooms available on the ward where carers and relatives could have the privacy and comfort to talk with the staff about very stressful and emotional life events affecting them.

One patient we interviewed found the bed very uncomfortable and mattress "lumpy". Also we were told there is a cold draught from the open window of the male toilet at the end of the ward near to the nurses' station. We observed and felt this draught. We were told the ward lights may not be switched off on occasions until midnight.

We were told that noise levels at night from disturbed patients can make the ward quite noisy for other patients trying to sleep. This is monitored by the Sound Ear.

5.2.6 Support for dementia

We observed that there was signage on the toilet and bathroom doors using a different colour with a picture and words to show if it was a shower, bath or toilet. Within the toilet and bathroom areas it was the same uniform white colour on the walls and the sanitary equipment making it challenging for a patient who has dementia with sensory and visual impairments to be able to safely find the toilet.

There was a good display of notices in the ward including information for relatives about the Dementia Passport although one carer we interviewed was unaware of this.

The white board behind the nurses' station with a list of patients showed 11 Butterfly Scheme signs against the senior health patients and this correlated with

the signs over the patients' beds. We were unable to establish if any carers had been informed of the "Reach out" form used in conjunction with the Butterfly Scheme. One of the carers we interviewed had been given no information about the scheme, despite being a very regular visitor. It was therefore difficult to establish how effective the Butterfly Scheme is regarding improving the care of patients with dementia and delirium.

We noticed that there was a display on the ward of the four 'top topics that staff were focusing on" in September. These included raising awareness of the Butterfly Scheme and Dementia Passports for carers. The nurse in charge had the credit card-like Dementia Passport example on her identity lanyard to show this example to carers.

5.2.7 Meals and Drinks

On arrival to the ward we asked if patients were provided with pictures for menu choices –this book was on a shelf above the food trolley space. However, we did not see this being used when patients were being asked shortly before lunch about which dish they would prefer. This would have been a helpful aid in the case of a patient who was obviously very hard of hearing. We observed the ward hostess explaining to a patient what a lasagne was in supporting them to make a choice of meal.

The staff did not rush patients during meal times and the majority of times they offered to cut up the patients' meal and asked if the patient was comfortable and needed any other assistance. We observed that patient's tables were generally moved within easy reach of the patient, although in one case a patient had to wait for some time without being able to eat, until a second nurse noticed that the table was not positioned appropriately.

We were advised that preparations for meal times occurred with patients being sat upright, their tables cleared, patients' hands cleaned and all male urine bottles cleared away but our observations did not bear this out.

We were told that relatives are actively encouraged to help at meal times if possible as well as St George's volunteers, who had formerly been attached to Dalby Ward. At our visit we did not see any volunteers but we found one carer who assisted and encouraged a patient to eat and drink.

It was interesting that the whole ward team helped with handing out meals and put on pink plastic aprons. This team approach included the housekeeper and receptionist as well as nurses and a speech and language therapist. We observed the receptionist being particularly friendly and caring. This helped to speed up the

time taken to serve the food by the domestic helper. We did not observe any offers of hand washing to patients while we waited for the meals to be served.

We observed an eight-bedded bay at lunchtime where most patients remained in bed with exception of one man who sat in his wheelchair. It was noticeable that urine bottles remained present during the meal. One man had a urine bottle next to his tray, another patient had three bottles on the window ledge next to his bed. We saw a male nurse help a patient to sit up to eat his meal. We also saw a patient lying on his side in bed who had his meal served and cut up by the receptionist but there was no enquiry if he would be able to manage to eat his meal lying down on his side in bed.

A carer that we spoke to told us that the relative does not like the food served so they bring in food and this is allowed. The patient we interviewed told us that the food was “average” but not “enough to sustain you” and they really wanted to eat “a steak”.

5.2.8 Discharge planning

We were told that there can be a lack of flexibility shown by nursing homes and this is challenging in discharge planning.

Although the patient we interviewed had had a meeting about discharge to a nursing home, it was clear that their concerns about the move had not been fully dealt with. A carer we spoke to had not had any information about future plans for discharge.

The only element that emerged from one carer was that their relative had been readmitted on a very “regular basis” over the last months despite an increase in community care in their home. The carer told us that the patient would be unable to cope at home and was anxious to speak to a nurse or doctor about these concerns. We passed on this detail to the nurse in charge.

5.3 Amyand Ward

5.3.1 Overall quality of care

All the patients we spoke to on Amyand Ward made positive comments about the overall standard of care that they had received. Some were unstinting in their praise of the ward and of staff while one reported a few limited incidents of poor practice in an otherwise favourable picture. Another had been less happy in the evenings, which we took to be a reflection of a certain lack of emotional support in their specific distressing circumstances. The relatives and carers we spoke to on balance were less positive: one said the ward was "OK -more or less", another

acknowledged that their relative's condition had improved after a week on the ward but expressed frustration about the difficulty of getting coherent information, while another felt that care was "not up to standard".

5.3.2 Admission

All the patients we spoke to or enquired about had been admitted on an emergency basis, mostly through A&E and/or the Richmond AMU. Three had had a fall and another two were in acute pain. The admission process itself had been problem-free so far as the patients were concerned apart from one patient who had had to wait two hours for an ambulance after an out of hours GP had visited in an apparent attempt to avoid admission.

5.3.3 Patient and carer involvement

We were interested to find out whether patients and their carers felt adequately involved in their care, whether the care plan had been explained clearly enough to them, whether they had been asked for feedback on the quality of their care and whether they knew how to raise concerns or, if necessary, make a complaint. We had ascertained before the visits that the ward did not provide patients or carers with written information on or before admission. The responses we got from patients and carers gave a mixed picture. Two of the patients felt that their care plans had been explained to them, in one case by the Ward Manager. Another patient said that the plan had not really been explained. One close relative said they only got information when they asked and a paid home carer who visited their client in hospital said that information was fragmentary and that it was difficult to find a doctor who could explain things. No one we spoke to had been asked for feedback and most had no clear idea how to make a complaint or who they could speak to if they had a concern to raise. One more confident patient had raised concerns with the Charge Nurse and had been happy with his response.

As to visiting, relatives and carers seemed to find the ward welcoming and most were happy with the visiting arrangements, although some had long journeys. One relative of a patient in a side room was pleased to be allowed more flexible visiting hours. But a relative of a patient in a bay who had a long journey had to stay overnight in London so was unhappy that they could not visit again in the morning.

5.3.4 Staff

We asked about the attitude, behaviour and responsiveness of ward staff, which seemed to us to be a key element in the quality of care.

The patients we spoke to were generally positive about staff, with certain limited exceptions. Not every patient could say who was looking after them that day (nurses' names were normally on a whiteboard behind the patient's bed where it was difficult for many patients to see it). But all seemed to experience a reasonable continuity of care, while recognising that there had to be changeovers. Nursing staff were reported to be generally good at introducing themselves. Only one of the patients was aware of having met the ward manager and the matron. We did however see the Ward Manager walking and chatting with a patient.

All the patients had good things to say about the attitude and behaviour of nursing staff. They were variously said to be "caring", "polite", "helpful", respectful of patients' privacy and dignity and understanding of older people's needs. Several patients needed help with personal care and received it. Nurses' response to calls from patients' buzzers was generally said to be prompt, although one patient said it took some time for the particular item asked for to be brought.

One patient while positive about the generality of nursing staff reported a number of limited instances where staff had been lacking in due consideration or respect, including two staff conversing in Spanish or Italian in front of a patient and two instances where staff on the night shift had been verbally aggressive and “bullying” to patients whose behaviour they considered to be unacceptable. The patient intended to discuss these incidents with the Charge Nurse.

The relatives and carers we spoke to gave us a mixed view of ward staff. One reported that their relative found the staff friendly and kind, although some nurses were rather rough in giving personal care. Another carer considered the personal care less than thorough and felt that while some staff were conscientious, others were not: they promised to do things such as record information in the care plan but didn't do them.

It is noteworthy that nearly every patient we spoke to on Amyand Ward and one of the carers described the nursing staff as "busy" or "too busy”. This seemed to apply particularly to the daytime staff. Despite what sounds like a relatively generous staff to patient ratio, at least one patient (and their relative) considered the ward "understaffed". The key indicator seemed to be that staff did not have time to explain things or to spend time talking to patients. In the case of one patient whose partner was critically ill elsewhere in the hospital, there did seem to us to be insufficient attention to their need for emotional support.

There were some positive comments from patients about the medical staff. We observed or were told of a number of instances of a respectful approach by doctors.

5.3.5 Ward environment and facilities

Patients and carers had little to say about the ward environment and facilities, perhaps reflecting the short time they had spent there and an inevitable preoccupation with more immediate healthcare issues. But as observers we were struck with the limitations of space on Amyand Ward: the corridor is narrow such that two people talking can block the movement of others and patients with Zimmer frames or drip stands have difficulty navigating their way. The bays had a cramped feeling – beds are close together, making it difficult for anyone to have a private conversation with a bed-bound patient and there is little space (and very few chairs) for more than one visitor to be comfortable. The dayroom supposedly shared with Allingham Ward is effectively out of reach for most patients and we doubt if it is much used. The apparent lack of support for activity other than reading, listening to radio or watching TV (which has to be paid for) is perhaps of minor significance given the ward's rapid throughput.

Patients commented on some specific issues, prompted by our questions. Most found beds comfortable and adjustable with staff help, but one patient found their chair seat too hard. The ward temperature was acceptable but one patient needed extra blankets at night. Our impression was that temperature was dependent on weather and that proximity to the large (South-facing) windows was also a key variable factor. Despite various references to people talking and laughing at night, noise did not seem to stop people sleeping. One patient admitted to being a poor sleeper in any conditions. There was unanimity on the cleanliness of the ward and one patient called the cleaning staff "marvellous".

Single-sex shower and toilet facilities were fully in evidence on Amyand with two wet-room style showers, one for male and one for female patients. However, we noted that one of the male toilets had been out of action since July. We were told that this was because the repairs needed involved structural work.

5.3.6 Support for dementia

Although we were told that four-fifths of patients currently on Amyand had cognitive or mental capacity issues and the majority of these were signed up for the Butterfly Scheme, designed to provide extra support for patients with dementia or delirium, we did not find it easy during our relatively short time on the ward to form any real assessment of our own on the effectiveness of this. One carer told us that it had taken several days to get staff to provide the Reach Out form used in connection with the Butterfly Scheme to record the patient's particular needs and preferences and to implement the red tray for meals (see below). On the other hand, a relative of another patient (who had been

disoriented following a fall) mentioned that the need to follow up this aspect of their condition after discharge had been picked up by staff.

We observed an HCA providing 1:1 care with a newly admitted patient. While apparently looking at a magazine himself, he also managed to have a relaxed and appropriate conversation with the patient about Hong Kong and their love of Chinese food.

We noted that bathrooms and toilets had their doors painted a different colour (green) and had (rather small) pictorial symbols denoting function and gender but access to some of the toilets and bathrooms was around corners and, apart from a recently renovated bathroom, there were no contrasting colours within the toilets and bathrooms. A more thorough-going approach to "dementia-friendly" design will no doubt have to await refurbishment.

5.3.7 Meals and drinks

The patients we spoke to were generally satisfied with the food and the meal arrangements. One patient mentioned that there were plenty of snacks but regretted the lack of toast at breakfast. Another was able to find food that suited their Asian taste. A patient who was diabetic was used to eating a lot of salads at home and was not too happy with the cooked meals; they liked the puddings but had to be careful. They did not seem to be getting any special diet or advice regarding eating while on the ward. A carer said that the patient they supported had lost a substantial amount of weight on a previous admission to St George's and had lost some during their stay on Amyand. Arrangements had been agreed for the carer to bring them food from Marks and Spencer and to make sure they ate well.

We observed the evening meal being served between 5 pm and 5.45 pm. This involved a major mobilisation of staff - we counted at least 8 nursing staff wearing aprons to help. Meals were served up by the ward domestic staff from a trolley positioned in the corridor by a whiteboard containing information on individual patients' needs. This listed 13 red trays (requiring special help) and a wide variety of special diets including diabetic, Asian, kosher, thickened/puree, cooked breakfast etc. Nurses served the grey trays (independent eaters) saying that this allowed them to focus on helping patients once the red trays were served. This meant that some of the more dependent patients had to wait several minutes while others in their bay were served before them and this gave rise to some agitation.

The main dishes were beef casserole with vegetables or meat balls in tomato sauce, both with mashed potato. There were also vegetarian meals provided. Pudding was sponge and custard (very popular). Some patients did not want the cooked supper, and we saw nurses trying to tempt these people with soup, cheese

and biscuits, or sandwiches. Fruit juice was served. The relative of one patient asked if there was any ice cream, as their relative would prefer this to sponge and custard, but it was not available.

We paid particular attention to the help being given or not given to patients and saw examples of what we took to be good as well as some less good nursing practice. We saw two instances where nurses gave patient friendly (if largely task-focussed) support, encouragement and practical help for patients with red trays to get started on their meal before leaving them to manage successfully on their own.

In another instance a nurse brought a red tray with soup, for which the patient had asked, saying she would come back to help in a few minutes when it had cooled. She did not reappear, so the patient tried to manage on their own, very slowly and with some effort. After around 10 minutes, another nurse came, lowered the bed table so that it was at a more convenient height for the patient, and helped with the soup.

Another patient lying in bed, who was not served a red tray, seemed in practice to need as much help as those with red trays. After the food was ignored for some time a nurse came and stood by the patient, encouraging them to eat. She left and the patient soon stopped eating. Another nurse came and mashed up the pudding and put it in front of the patient but they didn't eat it. The patient got up and started to walk away until stopped by a nurse. A staff consultation ensued and a nurse took the patient back to the bed and stayed with the patient to help them get started eating again.

Two distinctly less satisfactory mealtime situations observed were: a patient with a scalp wound being coaxed to eat while blood had leaked onto their pillow, and a patient happily eating their meal at a table with an apparently full urine bottle on it.

5.3.8 Discharge planning

The key factor determining discharge from Amyand Ward is normally the patient's medical condition although in some cases (including a few of the patients we spoke to) there are services to be organised or adaptations made at home. The ward has a discharge coordinator who is responsible for identifying such needs and ensuring they are properly assessed (usually by the ward's OTs) and addressed by the appropriate agency. We found satisfactory evidence of her activity, although only one patient was explicitly aware of her role, and most patients seemed to have a good enough idea of how long they were likely to be on the ward. But it did seem to us that there was a gap in terms of contact with relatives and carers, who are themselves sometimes elderly with health issues of their own, and who may be

called upon to play a vital role in ensuring the patient's wellbeing after their return home. One particular instance concerned a patient whose spouse was unaware, after several weeks of the patient's stay, of the existence of a discharge coordinator. Moreover, they reported having been telephoned the day before "by a young lady" and told the patient was shortly to be discharged. This subsequently turned out to be a mistake (or at least there was a medical decision to the contrary). We spoke briefly to the discharge coordinator during our visit and, while it was apparent she had adequate sources of information about patients' needs, including through the daily multi-disciplinary team meeting, she did not seem to see it as part of her role to consult family carers about discharge arrangements but only to inform them when the discharge decision had been taken.

6.0 Senior Health Wards at St George's Hospital: overall conclusions and recommendations

6.1 Conclusions

The three wards we visited represent the core of St George's Senior Health service. They operate independently but as part of an integrated system under the operational leadership of a single matron and subject to the Trust's strategic governance. Their primary purpose is medical: we are not in a position to assess their clinical performance, but we heard no suggestion that they are other than generally successful in what they do.

Our visits focussed mainly on the experience of patients and their relatives and carers which is in itself a crucial aspect of the quality of care. Most of the verbal evidence we obtained from patients was positive, some of it unreservedly so. We had ample opportunity to observe the difficulty of providing nursing care to people who are confused or experiencing cognitive impairment and the dedicated efforts of the staff to meet their needs. We were particularly impressed by the clear leadership of the matron, Sharon Lynagh, and the commitment to improvement shown by her and other clinical staff we spoke to. But we both observed and heard of some lapses in care or in nursing standards relating to respect, tolerance, interaction, support with eating and even basic hygiene. Many of these seemed to bear out what we were frequently told, namely that despite apparently generous staffing ratios nursing staff, particularly in the daytime, are constantly busy if not overstretched. Generally high standards of respect for patients' dignity and privacy are maintained but these aspects, together with the ability to give elderly and confused patients the time and attention they sometimes need, seem particularly vulnerable to pressure. In the case of Amyand and Rodney Smith wards the pressure of time was exacerbated by the limitations of space.

We were told of and observed systems in place, such as the Butterfly scheme and the red trays, to ensure that particular attention is paid to the needs of patients with dementia, delirium or having other special needs. We did not feel able to make an overall assessment of how well these systems were being applied but we encountered examples of both good and less good practice.

The fact that the overwhelming majority of patients on these three wards are living with dementia or suffering from a temporary impairment of their mental capacity does in our view suggest that the principles and practices of care required for such patients are not to be seen as "extras" but as the default situation. This clearly has implications for the training and supervision of staff but also perhaps for the continued use of specific systems like the Butterfly Scheme which treat dementia and delirium as an exception. It also has implications for the treatment of the minority of patients who although physically frail remain in full command of their mental faculties. We found some such patients who felt that in one way or another their situation was not being fully respected. In our view some thought may need to be given to how the interests of this group of patients might be better protected, particularly on the longer stay wards.

Also on the longer stay wards we were concerned about the apparent lack of activity and stimulation for patients who could benefit from it. We have also reported some carers' concerns that not enough attention may be being paid on these wards to maintaining patients' mobility.

Perhaps understandably, carers were more inclined to notice lapses and raise issues about care than the patients themselves. Although relatives and carers felt welcomed in the wards, several of them had what sounded like justifiable concerns about the lack of or fragmentation of the information available to them about the functioning of the ward and about the progress of their relatives' condition. Several carers we spoke to, some of whom had travelled some distance, were not aware of the possibilities of flexible visiting times. On Amyand Ward in particular, where patients can be discharged after quite short stays, we were concerned to hear that partners and other carers (many of whom are likely to be elderly or infirm themselves) were not routinely being involved in discharge planning and might not be contacted until a discharge decision was taken. We felt that the limited evidence we obtained on discharge planning on Heberden and Rodney Smith wards also indicated some weaknesses in providing reassurance to patients and carers. The fact that the role of discharge coordinator rotated on Heberden as apparently no one wanted to take it on might also be a weakness. Some carers were not happy with the treatment of their relatives in the AMU which the Enter & View team did not visit on this occasion.

We set out below some suggestions for improvement or areas requiring further consideration.

6.2 Recommendations

6.2.1 Improving quality of care

Although we saw a great deal of good practice, including strong leadership from the Matron Sharon Lynagh, we believe that more could be done to ensure that consistently high standards of care are met, including in the following areas:

- Ensure that patients do not develop new bedsores;
- Patients are helped appropriately with eating and drinking and that proper hygiene standards are maintained at mealtimes (e.g. no urine bottles on tables; handwashing for patients);
- Help patients to communicate their needs more effectively e.g. through the consistent use of pictorial menus;
- Prioritise the maintenance of patients' mobility levels at or above those they had on admission;
- Ensure that patients are treated with dignity and respect at all times and that they are as involved as much as they are able to be in decisions about their treatment and future;
- Increase the amount and quality of interaction between staff and patients through communication and conversation when providing care, observations and treatment;
- Pay more attention to patients' personal appearance to include hair-washing and hairdressing as appropriate;
- Pay more attention to the emotional needs of patients, including identifying signs of depression and, where appropriate, considering referral to the expanded older people's sub-team of the liaison psychiatry service;
- Address the need for patients to have meaningful ways to be occupied whilst in hospital (see in more detail below under ward environment and facilities). We share the view of the Alzheimer's Society that patients with dementia need substantial support and stimulation from staff and carers to avoid the potentially detrimental effects of an unfamiliar hospital environment.
- We consider that the use of Reach Out or other similar documentation (to collect information about patients' backgrounds, needs and preferences) with all senior patients and their carers at the time of admission would greatly assist the personalisation of care and help to ensure consistently high standards of individualised care.
- We believe improved care in these and other areas should be supported by targeted training and supervision and peer review across wards.

- We invite the Trust managers to provide a view on whether current staffing resources are sufficient and appropriately deployed to achieve consistently high standards in all of these areas or whether changes in resourcing are needed to reduce pressure and improve consistency of care.

6.2.2 Patients with mental capacity

We became aware from the minority of patients on these wards who were without significant cognitive impairment that they can experience difficulty and discomfort on the senior health wards. We should therefore like to recommend that the Trust:

- Makes every effort to treat older patients with full mental capacity on general medical wards, if necessary by providing additional support to those wards.
- Ensure that on the senior wards those with mental capacity are treated appropriately as well as being fully involved in their treatment decisions, rather than assuming that carers need to fulfil this role.
- Consider whether the refurbishment of the senior health wards provides the service with an opportunity to address how the needs of those with greater mental capacity and physical frailty can best be met.

6.2.3 Carer involvement

We consider that standards of practice in relation to carers could also be improved in some areas:

- Consider whether there is a role for "carer champions" or "carer leads" among ward staff.
- Nurses and medical staff should ensure that carers and family members are regularly updated about the progress of their relative and that they are offered opportunities to raise questions and concerns on a regular basis.
- Ensure that each ward has a permanent, rather than rotating, discharge coordinator so that good and consistent practice can be developed;
- Ensure that the discharge coordinator role formally includes liaising with families so that carers and partners of patients are fully involved in all stages of the discharge process;
- Enact flexible visiting times for carers and close family members of all patients on senior health wards not just those with dementia or on the Butterfly Scheme and adjust the notices at the entrances to wards to reflect this;
- Ensure staff are aware of the Alzheimer Support worker role to support carers and signpost them in the community.

6.2.4 Written information

Whilst we recognise that most patients will not be able to use written information, we think that brief Information packs or leaflets should be prepared for each ward or for the three senior wards collectively. At a minimum these should outline what patients and carers can expect from a stay on these wards, give named contacts for carers and name of the Consultant, information about interpreting services and guidance about how to raise any concerns or make a complaint.

6.2.5 Ward environment and facilities

Finally, we have a number of specific recommendations in relation to the ward environment and facilities:

- When Amyand and Rodney Smith come to be refurbished, consider the scope for improving effective space standards as well as the application of dementia-friendly design.
- Specify that all shower rooms should in future be step-free wet rooms.
- Ensure that all call bells are working and within the reach of patients, especially in side rooms.
- Provide light-weight easily moveable chairs for visitors in each bay.
- All wards, once refurbished, should have a space for private conversations between carers and patients or carers and staff as well as for larger meetings.
- Introduce activities and stimulation which can be provided by the bedside as most patients are bed-bound and on Amyand Ward there is no dayroom on the ward.
- Routinely ensure that the access to the radio is activated for every patient as soon as possible after admission and provide headphones.
- Provide free access to TV and wifi for senior patients and their carers and encourage use of the TV for patients.

Revised 17 November 2017

Disclaimer

Please note that our findings in this report relate to observations and interviews on particular days. It should not be taken as a representative portrayal of the experiences of all service users and staff on the wards involved over time.