Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 37, Royal Alexandria Hospital, Corsebar Road, Paisley, PA2 9PN

Date of visit: 5 December 2019

Where we visited

Ward 37 is a short stay 20-bedded ward providing psychiatric assessment and care for people with dementia. We last visited this service on 9 April 2019 and made recommendations relating to care planning and life history, the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'), and treatment under part 16 of the Mental Health Act, consultation with proxy decision makers, and the physical environment.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendations.

Who we met with

We met with and/or reviewed the care and treatment of six patients.

We spoke with the senior charge nurse (SCN), charge nurse, occupational therapist (OT) and occupational therapy technician.

In addition we met with the visiting art therapist.

Commission visitors

Mary Hattie, Nursing Officer

Anne Buchanan, Nursing Officer

Lesley Paterson, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The ward has regular input from OT, psychology and physiotherapy. Additional input from other allied health professions and specialist services is available on a referral basis. The ward has input from four consultant psychiatrists. We are advised that the ward often has a waiting list and patients have to be "boarded out" in other hospitals in the city until a bed becomes available. At the time of our visit there were three patients on the waiting list for admission who were in beds in other sectors of the city. There were three patients who required ongoing NHS care and were awaiting beds, and one patient awaiting a care home placement.

We had previously made recommendations relating to care plans. On this visit we found that there had been considerable work undertaken in this area. There were completed risk assessments and initial assessments in the files of all the patients whose care we reviewed, although the quality and amount of information in the initial assessments varied considerably.

We found care plans in all the files we reviewed, and the majority of these were being evaluated on a regular basis. The level of detail contained in the care plans and the frequency of reviews varied, with some very detailed and some requiring further development. We found that physical health needs were being managed well and this was reflected in the care plans. We found stress and distress care plans, developed using the Newcastle model, in the majority of files we looked at.

We are advised by the SCN that work is ongoing around improving the quality of care planning and ensuring these are updated to reflect changes in care. An audit tool is being developed, and monthly audits will be implemented to ensure care plans address all identified needs.

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

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We made a recommendation previously in relation to recording life history information as this is essential to the development of person-centred care plans and the delivery of person centred care. We found "Getting to Know Me" forms in all the files we reviewed these contained varying levels of detail. This is a document which records a person's needs, likes and dislikes and background, and is aimed at helping hospital staff understand the person and how best to provide person centred care. The information these contained had been used in the development of person-centred care plans. We also note that a newly appointed support worker has been tasked with supporting patients and families to complete this information early in their admission.

We found some evidence of involvement of proxy decision makers and families in care plans and decisions about future placement. We are advised that relative involvement and support is provided on an ongoing basis and that discussions with families around ceilings of care are being implemented, and there are plans to look at ways to develop carer support further.

Where there is no guardian or attorney for a person who cannot consent to a decision about cardio pulmonary resuscitation (CPR), it is a requirement to consult with the close family, as well as trying to establish the wishes of the patient. In all cases, this involvement or consultation should be recorded. In all the care files we reviewed which contained 'Do not attempt CPR' forms which had been completed on the ward, there was evidence of discussion with nearest relative or proxy as appropriate.

Recommendation 1:
Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the care needs of each person, identifying clear interventions and care goals, and setting out review timescales.

Use of mental health and incapacity legislation

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act.

All the patients whose care we reviewed lacked capacity to consent to treatment. In each case there was a completed s47 certificate and treatment plan, and proxy decision makers or relatives had been consulted appropriately.

Where individuals had granted a power of attorney this was recorded, and a copy of the powers was held in their care file.

On the day of the visit eight patients on the ward were detained under the Mental Health Act. We found copies of all the detention paperwork on the patients care files and in the electronic patient record.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment forms (T3) completed by the responsible medical officer to record non-consent were all in order as appropriate.

We were advised by the senior charge nurse that an audit tool is being implemented to ensure that this level of compliance is maintained.

Rights and restrictions

Entry and exit from the ward is controlled by staff via a keypad system to maintain patient safety. There are notices advising visitors to wait for staff to let them in or out. We found risk assessments in the files we reviewed which addressed the need for a locked door.

There are posters within the ward advertising the local advocacy service and providing contact details. We are advised that advocacy visit the ward regularly.

There are posters setting out visiting times, but advising that visits outwith these times can be arranged. We are advised that person-centred visiting is being implemented, where visiting arrangements are being tailored to the needs of the individual and the family and this is working well.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

This can be found at https://www.mwcscot.org.uk/rights-mind/

Activity and occupation

The ward has a full-time occupational therapist and technical instructor, shared with a neighbouring ward. There is a regular programme of activities including football memories, musical memories, therapet, art groups, lunch groups, coffee mornings, and individual and group outings to use community facilities or visit at home. On the day of our visit three patients were going out, either with staff or family members.

Whilst there is evidence of activity participation in the files and the ward programme, individual activity care plans have not yet been developed.

A support worker has been appointed and started work on the day of the visit. One of their roles will be to support patients and their families in completing "Getting to Know Me" and "What Matters to Me" documentation, which informs person-centred care and identifies activity preferences.

We are advised that wi-fi is being installed in the ward this week and the iPads have been reconfigured to enable staff to begin using them with patients to support individual engagement and activities. A bid is being submitted for the provision of a Tover tafel (magic table) which can be used for individual and group activities.

Recommendation 2:
Managers should ensure that person-centred activity care plans are in place for each patient, reflecting the individual's preferences (alongside activities specific to their care needs).

The physical environment

The ward has a large dining area, a large sitting room with an adjoining conservatory, and a small activity room. Sleeping accommodation comprises of five en-suite single rooms and three five bedded dormitories. The ward appeared clean and free from odour when we visited. A dementia audit has been undertaken since our last visit and as a result a number of improvements were underway. Many of the memory boxes were in use, the garden area has been replanted, new blinds and curtains have been fitted and the ward will be redecorated early in the new year. Additional dementia friendly signage will be installed once the redecoration is complete.

We were advised that a bid has been submitted for further improvement works, including new showers and sensor taps. A bid is also being developed for new dementia friendly furniture, including a wellness chair, which has inbuilt speakers and a rocking mechanism. This has been trialled in other areas and found to be beneficial in reducing agitation. We look forward to seeing the finished improvements on our next visit.

Summary of recommendations

1. Managers should ensure nursing care plans are person-centred, containing individualised information, reflecting the care needs of each person, identifying clear interventions and care goals, and setting out review timescales.
2. Managers should ensure that person-centred activity care plans are in place for each patient, reflecting the individual's preferences (alongside activities specific to their care needs).

Good practice

The ward has invested significantly in training for staff. Two nurses are stress and distress trainers; stress and distress training has been provided for all trained staff and a programme of 'bite sized' training for nursing assistants is being rolled out. Two nurses are medical emergency trainers, one nurse is a specialist tissue viability nurse, two nurses are specialist palliative care nurses, and all staff have had training in palliative care. Two of the charge nurses have recently completed the dementia specialist improvement leads programme.

Service response to recommendations

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

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

MIKE DIAMOND
Executive Director (Social Work)

About the Mental Welfare Commission and our local visits

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

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons Inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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