Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 39, Royal Alexandra Hospital, Corsebar Road, Paisley, PA2 9PN

Date of visit: 5 March 2020

Where we visited

Ward 39 is a 20-bedded short-stay ward providing care and treatment for older adults with a functional mental illness. The ward has a large open plan sitting and dining area, a conservatory which opens onto a small garden area, a multi-purpose activity room and small sitting area. Sleeping accommodation is comprised of a number of small dormitories and single rooms. The ward is situated within Royal Alexandra Hospital. We last visited this service on 5 September 2019 and made a recommendation about care planning.

On the day of this visit we wanted to meet with patients, follow up on the previous recommendation, look at activity provision, and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

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), members of the nursing team, two consultant psychiatrists, the occupational therapist and physiotherapist.

Commission visitors

Mike Diamond, Executive director (Social work)

Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The ward had 14 of its 20 beds occupied on the day of our visit. We were told that occupancy levels had dropped over recent months, and this may be attributable to an increase in capacity within one of the community teams.

The ward does receive patients who are boarded in from other areas when their beds are full. Two patients were boarded in on the day of our visit.

At our last visit we heard there were issues with delayed discharges. This situation has now improved considerably with the introduction of the trackcare monitoring system. We heard that the timescales for applying for guardianship, where this is required, has decreased recently.

The ward has regular input from occupational therapy (OT), physiotherapy, psychology and pharmacy. Additional input from other allied health professions and specialist services is available on a referral basis and we were told responses are prompt and supportive. There is input from four consultant psychiatrists who each hold weekly multidisciplinary team (MDT) meetings. These are attended by nursing staff, OT, pharmacy, medical staff and social work with input from psychology, physiotherapy and community nursing staff as required. Patients and their carers / relatives are invited to the meetings to discuss their progress and treatment plans.

MDT notes are generally informative, providing clear information on decisions regarding treatment plans; however, the recording of attendance at MDTs is inconsistent.

Most patients we met with spoke positively about their care and treatment in the ward, they told us staff were approachable. We observed nursing staff interactions with patients that were professional and respectful. Staff we spoke to were knowledgeable about the patients when we discussed their care.

There is evidence in the chronological notes of communication with carers/relatives via telephone calls and face to face meetings. Visiting is flexible to take account of individual circumstances.

Patient's notes are currently recorded in two separate formats. Egton Medical Information Systems (EMIS) records chronological and MDT documentation electronically, with all other notes held on paper file. While this is not ideal, we were told EMIS will in the future be able to accommodate all information relating to patient's care and treatment. We welcomed this recent update and hope to see fully integrated records soon.

Risk assessments were detailed, regularly reviewed, and updated. Initial assessments were detailed and informative. Care plans we reviewed addressed both the mental health and physical needs of patients.

When we last visited Ward 39 we found care plans did not clearly show the patient's progress during their admission to hospital. Care plans were compiled soon after admission and were reviewed regularly. Reviews contained information on progress or changes in patients' needs and treatment. However this was not reflected in the care plan itself, which was not updated to include this new information and reflect the care being delivered. This remains the case.

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 had concerns over some aspects of care for one patient with very complex physical and psychiatric needs. These were discussed with his consultant and the senior charge nurse on the day and have now been resolved.

Recommendation 1:

Managers should ensure that MDT notes include a record of who attended and contributed to the meeting.

Recommendation 2:

Managers should ensure care plans are consistently updated following reviews to reflect the relevant changes to patients' presentation and care needs.

Use of mental health and incapacity legislation

Four patients in the ward were detained under the Mental Health Act, copies of detention paperwork were on file. However, in the chronological notes, we found instances where the legal status of the patient was inaccurately recorded.

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. We found that a number of T3 certificates, required under the Mental Health Acct, did not include 'as required' medication. However, whilst prescribed, this had not been administered. We raised this with the SCN who arranged for the consultants to review the patients medication chart, and either remove the prescription or request a DMP visit to authorise the treatment.

Where patients were subject to additional restrictions they had been made specified persons under the Mental Health Act and the appropriate paperwork was in place.

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

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 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.

We found a completed s47 certificate and treatment plan in the notes of the patient we reviewed, who lacked capacity and the proxy decision maker had been consulted.

Recommendation 3:

Managers should ensure that the legal status of patients is accurately and consistently recorded within the chronological notes.

Recommendation 4:

Managers should put an audit system in place to ensure that all medication prescribed under the mental health act is properly authorised.

Rights and restrictions

The ward door is secured by a keypad. The code for this is on the wall beside the door to enable visitors and patients, not subject to restrictions under the Mental Health Act, to leave the ward.

Posters for the advocacy service were on display and we found evidence of advocacy involvement within chronological notes and from discussions with patients.

Patients whom we spoke to, who were subject to detention, were aware of their rights of appeal and legal representation.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

There was a daily activity programme on display and we found some evidence of activity participation within the chronological notes, including exercise groups, music groups and individual outings provided by the OT and physiotherapist. We were advised that, due to the high levels of clinical activity, nurses' involvement in activities is limited at present. There have been staff shortages within occupational therapy recently which has also impacted on the activities available. However the vacancy has now been filled and the ward is also about to benefit from having an OT support worker who will focus on activity provision. We look forward to seeing the impact of this on our next visit.

We met with the OT and physiotherapist and heard about the current joint exercise and social groups which they run every fortnight and the plans to re-establish therapeutic groups such as cognitive behaviour therapy, now that vacancies within the OT service and psychology are filled.

The physical environment

The ward has had some refurbishment since our last visit and day and dining rooms are bright and well decorated. Corridors and dormitories have been repainted. The activity room is a multipurpose room used by physiotherapy, nursing and occupational therapy staff. A capital bid has been submitted to refurbish this room and make other improvements to the ward environment to meet the needs of the client group. The occupational therapist highlighted the need for a therapeutic kitchen to enable kitchen assessments and cooking practice to take place on a regular basis. Currently the ward shares a kitchen with the community staff group located next door, which significantly limits the availability of kitchen access and the suitability of the space for therapeutic work. We look forward to seeing the outcome of these improvements on our next visit.

Summary of recommendations

1. Managers should ensure that MDT notes include a record of who attended and contributed to the meeting.

2. Managers should ensure care plans are consistently updated following reviews to reflect the relevant changes to patients' presentation and care needs.

3. Managers should ensure that the legal status of patients is accurately and consistently recorded within the chronological notes.

4. Managers should put an audit system in place to ensure that all medication prescribed under the mental health act is properly authorised.

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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