Mental Welfare Commission for Scotland

Report on announced visit to: Ward 37 Royal Alexandria Hospital, Corsbar Rd, Paisley

Date of visit: 8 July 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been able to conduct our face to face visits, however, the reinstatement of lockdown required us to review this, and we are presently undertaking mainly virtual visits. This local visit was able to be carried out face-to-face.

Ward 37 is a 20-bedded ward which provides psychiatric assessment and treatment for older adults with dementia. Accommodation is provided in five en-suite single rooms and three dormitories with five beds in each.

We last visited this service on 5 December 2019 and made recommendations in relation to care planning and activity plans.

On the day of this visit we wanted to follow up on the previous recommendations and also look at issues related to visiting, family contact, activities and care planning.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and seven relatives.

We spoke with the operational nurse manager and the charge nurse.

Commission visitors

Mary Hattie, Nursing Officer

Mike Diamond, Social Work Officer

What people told us and what we found

On the day of our visit the ward had 20 patients, nine of whom were detained under the Mental Health (Care and treatment) (Scotland) Act 2003 ('the Mental Health Act').

We were told that there had been two Covid-19 outbreaks in the ward, one early in the pandemic and a further one earlier this year. During the first wave all the patients contracted Covid-19 and staff were also badly affected. The second outbreak again affected the majority of patients. There were two deaths during each wave as a result of Covid-19.

The pandemic has had a significant impact on the service. For much of the time visiting was stopped however this was restarted as early as possible due to the distress that lack of contact caused to both the patients and their relatives. Much of the allied health professions input was virtual during this period, with the exception of occupational therapy, who continued to provide recreational and therapeutic activities within the ward. We are told that the majority of services have now resumed face-to-face contact.

Care, treatment, support and participation

The ward has regular input from occupational therapy, physiotherapy and psychology, additional input from speech and language therapy, dietician and other allied health professionals and specialist services is available by referral.

Of the four consultant psychiatrists attached to the ward, two are currently locums. Multidisciplinary team meetings (MDT) are attended in person by the consultant, nursing staff. The occupational therapist, pharmacist, psychologist and social work staff join via teams. Notes of MDT meetings are recorded on Emis, the electronic recording system. Families are currently unable to attend reviews; however there are discussions underway to restart this, either in person or via teams. We were told that the consultants normally provide feedback to families, or if not this is done by nursing staff. However several relatives that we spoke to told us that they did not feel involved in decisions and that communication from the ward was poor, with little or no proactive contact by the ward. We felt that the action to update relatives should be recorded in the note of the meeting, so that it was clear to all staff who was responsible for initiating relative communication.

The psychologist takes the lead in providing formulations using the Newcastle model for patients suffering from stress and distress, and undertakes individual work with patients and families. Two of the charge nurses have undertaken Dementia Improvement Specialist Lead training.

In the notes and care plans we reviewed we found that physical health care needs were being addressed with patients being referred for specialist review or follow up when required. However we found that many of the care plans were not updated to reflect the current situation, and care plan evaluations were chaotic and confusing.

Despite the specialist skills within the ward team we found evidence of some patients experiencing stress and distress, who were prescribed medication and required restraint to manage this, with no care plan for managing this.

Where care plans were in place for stress and distress these made reference to use of distraction, with no detail of the triggers or effective management strategies for the individual. We found one patient had been referred to and assessed by the violence reduction team, who had provided advice on management but did not have a care plan for managing their distressed behaviours.

We heard from relatives that information they provided about what was important to their loved one was not recorded or acted upon despite being provided on a number of occasions.

There was completed "getting to know me" documentation for the majority of patients. This is a document which contains information on an individual's needs, likes and dislikes, personal preferences and background, to enable staff to understand what is important to the individual and how best to provide person-centred care whilst they are in hospital. However, these are kept separately from the patients care plans, and of those we reviewed the document contained very little meaningful information and had not been used to inform their care plans.

This information is essential not only for providing care in the current ward, but as many of the patients will move on to further care placements it is important that this information is recorded and follows them through their care journey.

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

Recommendation 1:

Managers should ensure that care plans are evaluated and updated to reflect changes to patients' needs and the effectiveness of interventions.

Recommendation 2:

Managers should ensure there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and this should be reviewed regularly.

Recommendation 3:

Managers should ensure that "getting to know me" and other life history documentation is fully completed and follows patients when they move to other care settings.

Use of mental health and incapacity legislation

Where individuals were subject to detention under the Mental Health Act, current detention paperwork was present in the files.

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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required and authorised all treatment prescribed.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') there was not always a copy of the powers on file and proxies were not always being consulted appropriately, or were not being recorded as proxy on section 47 certificates, and DNACPR forms. We suggest the use of the Commissions checklist for ease of ensuring guardianship or power of attorney details are contained in individual files. The checklist can be found on our website:

http://www.mwcscot.org.uk/media/51918/Working%20with%20the%20Adults%20with%20Incapacity%20Act.pdf

Where individuals lacked capacity to make decisions about their health care, s47 certificates, which authorise treatment under the AWI Act, were in place.

Recommendation 4:

Managers should ensure that where there is a proxy decision maker, this is recorded and the legal proxy is consulted appropriately.

Rights and restrictions

Visiting has been re-established in line with government guidance, with two nominated visitors per patient. Visits have to be booked in advance, and we heard from a number of relatives that due to the limited space available for visits it is difficult to get booked into a suitable slot.

We heard from the staff that where patients are in a single room they can more easily accommodate visits; however, where patients are in shared dormitory spaces, the only suitable place for their visits is in the ward activity room which is used by the occupational therapy staff providing activities for much of the day. This limits the availability of visiting slots for the majority of patients and means they cannot accommodate all the visit requests they receive.

We heard that there are iPads and phones available to enable to support contact with relatives; however we also heard from relatives that it was difficult to have phone or video calls arranged where the individual needs support to use the technology.

We were told that it is not always possible to support patients having visits home due to the limited number of single rooms, which causes difficulties in accommodating patients should they require to quarantine on their return.

We noted that there was no information about the provision of advocacy services on display in the ward. When we asked about advocacy provision there was a lack of clarity around who provided this.

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

Recommendation 5:

Managers should review the visiting arrangements to maximise the number of visits which can be accommodated and ensure that patients are able to receive visits as frequently as possible.

Recommendation 6:

Managers should ensure that patients who require support to use technology to maintain contact with family are supported to do this.

Recommendation 7:

Managers should ensure that advocacy services are available to patients and information about this is displayed within the ward area.

Activity and occupation

The ward does not have a patient activity co-ordinator, but has input from a part time occupational therapist and an occupational therapy support worker who provide assessments and a range of therapeutic and recreational activities on a one-to-one and group basis. This service has continued throughout the pandemic.

Whilst access to a range of external supports such as therapet, music therapy and reminiscence boxes from local museum have ceased due to the pandemic, the occupational therapy team have continued to provide a range of group and individual activities and have used technology to replace some of these resources. There are virtual music sessions via teams with the music therapist, iPads are used in reminiscence sessions, allowing access to pictures, videos and music which is meaningful to the individual, and, whilst group numbers have had to be reduced to accommodate social distancing, this has in part been compensated for by increasing the number of ad hoc groups happening.

We found an activity programme on the wall of the day room and dining room and activity participation was recorded in the chronological notes.

The physical environment

We have made recommendations regarding the physical environment in previous reports. The ward layout is not suitable for meeting the needs of the patient group and the environment remains dismal. During our last visit we were told that a bid had been submitted for new furniture and to replace the unsuitable showers and taps.

Redecoration was scheduled and the garden, whilst very small and uninviting, had been re-planted.

It was disappointing therefore to find that the garden was again neglected, although there are a few planters which have been filled by the ward gardening group. Redecoration had not been undertaken and new furniture has not yet arrived. We were advised that the redecoration and new furnishings have been delayed due to the pandemic, and this work will be undertaken.

However even with this work completed, the ward layout with the majority of beds provided in shared dormitory accommodation, and very limited communal space, will still not provide an environment conducive to meeting the needs of this patient group. We were told again by nursing staff that the current fixed head showers do not provide the flexibility needed when providing personal care for patients who require assistance with showering and may be incontinent. However, despite our initial recommendation in January 2018, which was repeated in April 2019, there are no plans to address the issue of the unsuitable showers and taps.

Recommendation 8:

We recommend that a full environmental audit is commissioned and an action plan is developed to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group. Managers should highlight our concerns in relation to the environment to the chief executive officer and we will also write directly to express our concerns.

Any other comments

We heard from one relative that there were difficulties with the laundry system, with clothes going missing from the ward and other patients' clothes finding their way into the laundry they took home. Staff told us that this was an ongoing issue which was difficult to address due to lack of space to store both clean and dirty laundry within the ward and the nature of the patient group.

Recommendation 9:

Managers should undertake a review of the current system for managing both hospital and take home laundry and take necessary actions to ensure a more efficient system.

Summary of recommendations

1. Managers should ensure that care plans are evaluated and updated to reflect changes to patients' needs and the effectiveness of interventions.

2. Managers should ensure there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and this should be reviewed regularly.

3. Managers should ensure that "getting to know me" and other life history documentation is fully completed and follows patients when they move to other care settings.

4. Managers should ensure that where there is a proxy decision maker, this is recorded and the legal proxy is consulted appropriately.

5. Managers should review the visiting arrangements to maximise the number of visits which can be accommodated and ensure that patients are able to receive visits as frequently as possible.

6. Managers should ensure that patients who require support to use technology to maintain contact with family are supported to do this.

7. Managers should ensure that advocacy services are available to patients and information about this is displayed within the ward area.

8. We recommend that a full environmental audit is commissioned and an action plan is developed to deliver an environment that is fit for purpose and supports staff to meet the complex needs of this patient group. Managers should highlight our concerns in relation to the environment to the chief executive officer and we will also write directly to express our concerns.

9. Managers should undertake a review of the current system for managing both hospital and take home laundry and take necessary actions to ensure a more efficient system.

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.

ALISON THOMSON
Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

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

The 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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