Mental Welfare Commission for Scotland

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

Date of visit: 31 August 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 unable to conduct our face-to-face visits; however, this local visit was able to be carried out face to face.

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.

We last visited this service on 5 March 2020 and made recommendations related to the quality of documentation and the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision and visiting as Covid-19 restrictions ease.

Who we met with

We met with and/or reviewed the care and treatment of seven patients. No relatives requested to meet with us. We spoke with the senior charge nurse (SCN) and charge nurse.

Commission visitors

Mary Hattie, Nursing Officer

Gordon Skilling, Medical Officer

Yvonne Bennett, Social Work Officer

What people told us and what we found

In the initial stages of the pandemic the ward relocated to Dykebar hospital for a short period due to staffing issues across the service, but returned to RAH during summer 2020. The ward experienced two outbreaks of Covid-19: one at the time of the return from Dykebar, and a further one last November, during which 14 patients tested positive.

On the day of our visit the ward had 16 of its 20 beds occupied. We were told that the ward had not been at full capacity for some time. Of the current patient group, three were boarded in from the dementia admission ward and five were boarded in from the adult mental health ward. The patients who are boarding from the adult ward remain under the care of their original consultant.

There are particular challenges in providing care for such a diverse group of patients and meeting their very different needs. This is further compounded by the additional demands on nursing staff time due to the additional multidisciplinary team meeting (MDTs) each week as a result of this situation.

We were told that this challenging situation is due to a pressure on beds across the service. We heard that the ward has been running under capacity for much of the last two years.

Care, treatment, support and participation

The ward routinely has input from four consultant psychiatrists who cover the catchment area. There is regular input from occupational therapy (OT), psychology, physiotherapy and pharmacy. Input from other professionals including dietetics and speech and language therapy can be arranged on a referral basis. Social workers are involved on a case-by-case basis.

We heard that the ward now has two nurses trained in behavioural activation therapy (BAT) and there is agreement from management that they will have protected time to enable them to work with the psychologist and provide BAT groups for patients who would benefit from this approach.

MDT meetings are held weekly for each consultant, and there was good documentation of weekly ward rounds on the electronic record. This included a list of those present at the meeting, detail of the discussion and a clear action plan.

Within the care plans we reviewed during this visit risk assessments were documented and reviewed regularly, care plans were person-centred, and addressed risk and mental health needs. We also found detailed assessment and care planning for physical health care needs.

There were 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.

Despite the challenges of the last year in the ward we heard that the ward team maintained relative involvement in MDT's virtually, using telephone conferencing and "near me", and have recently recommenced inviting relatives to reviews in person. There were care plans for relatives' involvement and good records of proxy or family involvement in reviews and care decisions.

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

Use of mental health and incapacity legislation

During our previous visit we made recommendations in relation to the Mental Health Act. On this visit seven patients in the ward were detained under the Mental Health Act, copies of detention paperwork were on file.

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 where a T3 certificate was required to authorise treatment this was in place. Requests for review by a designated medical practitioner had been submitted for patients whose treatment would require authorisation shortly.

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

Where a patient 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 completed s47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity and the proxy decision makers had been consulted.

Within the chronological notes, and on the duty room board there was reference to patients being under AWI, however it was not clear whether this referred to receiving treatment under s47 or having a proxy decision maker in place.

Recommendation 1:

Managers should ensure that where it is recorded that a patient is subject to provisions of the AWI Act, the specific provision of the Act is identified, i.e. s.47, POA, or Guardianship.

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. The ward conservatory doors were open and patients were able to access the gardens and grounds freely.

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

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 is a calendar on the dining room wall with a programme of activities, which include quizzes, a volunteer wandering minstrel, relaxation and a number of group activities. On the day of the visit there was a crossword group taking place.

We found limited recording of activity in the patient's records we looked at, and no care plan for activities providing information on patient's previous interests and hobbies.

We were told that the full activity programme is not currently being delivered as the OT had been off for three weeks, and the OT technician post had been vacant for some months. The responsibility for provision of therapeutic activity is shared by nursing and OT staff. Nurses are currently providing a limited amount of individual and group activities; however, activity provision is much reduced. A new OT technician starts on Monday. We look forward to seeing a full activity programme being delivered collaboratively by nursing and OT staff on future visits.

The ward had a reminiscence interactive therapy aid (RITA) on loan for several months during the early stages of the pandemic. This was found to be very beneficial, providing patients with opportunities to engage in activities and supporting conversations. A bid for funding to purchase a RITA for the ward has been submitted. We look forward to seeing this in action on our next visit.

Recommendation 2:

Managers should ensure that activity care plans are developed reflecting the individual's preferences and care needs, and that activity participation is recorded and evaluated.

The physical environment

The ward atmosphere was calm and welcoming, the ward is clean and bright; however, the bed areas lack any personalisation. We commented in our previous report on the multipurpose activity room used by physiotherapy, nursing and occupational therapy staff. A capital bid had been submitted to refurbish this room and make other improvements to the ward environment to meet the needs of the client group. However, due to the pandemic, this has not progressed. We hope to see progress in this area on our next visit.

Summary of recommendations

1. Managers should ensure that where it is recorded that a patient is subject to provisions of the AWI Act, the specific provision of the Act is identified, i.e. s.47, POA, or Guardianship.

2. Managers should ensure that activity care plans are developed reflecting the individual's preferences and care needs, and that activity participation is recorded and evaluated.

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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