Mental Welfare Commission for Scotland

Report on announced visit to:

Royal Alexandra Hospital, Ward 37, Corsbar Rd, Paisley PA2 9PJ

Date of visit: 15 March 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was 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, on the day of our visit there were 18 patients on the ward. The ward has a multidisciplinary team (MDT) on site of nursing staff, psychiatrists, occupational therapy, physiotherapy, pharmacy and psychology, additional input from speech and language therapy, dietician and other allied health professionals and specialist services is available by referral. We last visited this service 9 July 2021 and made recommendations regarding care planning, proxy decision makers, visiting, access to advocacy, laundry service and the environment.

On the day of this visit we wanted to follow up on the previous recommendations.

Who we met with

We met with and or reviewed the care and treatment of ten patients and spoke with six relatives by telephone.

We spoke with the senior charge nurse, charge nurse and the occupational therapist. In addition, we met with the service manager and the lead nurse on teams in advance of the visit.

Commission visitors

Mary Hattie, nursing officer
Yvonne Bennett, social work officer
Anne Craig, social work officer

What people told us and what we found

Care, treatment, support and participation

Multidisciplinary team (MDT)

The ward has a MDT consisting of nursing staff, four psychiatrists, occupational therapy, physiotherapy, pharmacy and psychology, additional input from speech and language therapy, dietician and other allied health professionals and specialist services is available by referral. At the time of our visit, recruitment was underway for a new senior charge nurse as the current post holder was about to retire. We heard that the ward was short of trained nursing staff, and has had to utilise bank and agency staff on a regular basis to maintain safe staffing levels. This issue is being addressed through changes to the staffing ratio and ongoing recruitment.

The ward uses a mixture of electronic and paper records. MDT reviews are recorded on the EMIS electronic record keeping system, and MDT decisions were clearly recorded with evidence of relatives/carers being invited to review meetings and of consultation with proxy decision makers. We heard from relatives that where they were unable to attend reviews staff updated them on any changes to care and treatment.

Care plans

Care plans and evaluations are held in the paper record, with risk assessments and chronological notes being recorded on EMIS.

We found completed 'getting to know me' forms in the patients' files we reviewed. This document contain 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 the information contained in these forms was not reflected in the care plans, which were lacking in a person-centred focus.

We found recent detailed meaningful care plan evaluations in all the files we reviewed; however, this information had not been used to update the care plan to reflect changes in presentation, care needs, or legal status.

We saw 'what matters to me' information above each patient's bed. This is a one page summary of key information about the individual, which assists staff to provide care and engage with the individual.

We reviewed the files of a number of patients who were prescribed, and receiving, as required medication for agitation, or where there were references to stress and distressed behaviours.

For the majority of these patients there was a Newcastle Model formulation in place. This is a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge. However, this valuable information had not been used to develop a care plan for the management of their stress and distress outlining the triggers, de-escalation strategies and threshold for use of as required medication for that individual.

We heard from a number of relatives who commented very positively on the quality of care that staff provided along with their knowledge and understanding of their patients' needs and preferences.

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/node/1203

Recommendation 1:
Managers should, as a priority, review their audit processes to improve the quality of mental health care plans to ensure these are person-centred and updated, to accurately reflect the patient's current needs, planned interventions and legal status.

Recommendation 2:
Managers should, as a matter of urgency, ensure that there is a clear person-centred plan of care for patients who experience stress and distress, which incorporates the information from their Newcastle formulation, where this exists. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (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. Certificates authorising treatment (T3B) under the Mental Health Act were in place where required and covered all prescribed treatment.

Where patients had a proxy decision-maker appointed under the Adults with Incapacity (Scotland) Act 2000 (AWI Act), this was recorded. We found copies of the powers held by the proxy in the majority of files we reviewed; where these were not on file this was noted and a copy had been requested.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. We found completed section 47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity. The proxies we spoke to told us they had been consulted in relation to treatment decisions, however this had not been recorded on a number of the section 47 certificates we reviewed.

Recommendation 3:
Managers should audit section 47 certificates to ensure that consultation with proxy decision makers is recorded.

Rights and restrictions

The ward doors are controlled by a keypad. The ward has a locked door policy and has information on how to access/egress the ward, displayed beside the doors.

Visiting

On our previous visit we heard that, due to Covid-19 restrictions and the ward environment, it was difficult to accommodate all visiting requests and this was a source of concern for relatives. There have been changes to the visiting arrangements, with visiting being available between 10 am and 8pm. Visits continue to be booked in advance, with the ward now being able to accommodate up to 28 visits a day. We are advised by staff, and the relatives we spoke to, that there are no difficulties in arranging face-to-face visits.

Virtual visits

We were advised that the use of iPads and phones for virtual visits has reduced as visiting restrictions have changed. These remain available to support contact with relatives, however there are limitations on the use of this, due to the time required for staff to support patients to use the technology.

Advocacy

Following our previous recommendation there are posters and leaflets available in the ward providing information and contact details for the local advocacy service.

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

The ward has input from an occupational therapy support worker and an occupational therapy technician who provide a range of therapeutic and recreational activities on a one-to-one and group basis. At the time of our visit, the occupational therapist post was being recruited to, following the promotion of the previous post holder. Whilst access to a range of face-to-face external supports, such as therapet and music therapy, had not recommenced, the occupational therapy team had continued to provide a range of group and individual activities and used technology to replace some of these resources. There were virtual music sessions via teams with the music therapist, and virtual pet sessions. IPads are used in reminiscence sessions, allowing access to pictures, videos and music which is meaningful to the individual. Reminiscence boxes are provided from the local museum to support group discussion and activities. There are regular football memories groups, craft groups, coffee mornings, quizzes etc. as well as individual activities.

The ward has sessional input from an art therapist, who had recently undertaken a project with patients to create artwork for all the bedrooms.

There was an activity programme on display in the dining area, and we saw group and individual activities taking place during our visit.

In the chronological notes we reviewed we saw evidence of a wide range of activities being provided.

The physical environment

We have made recommendations regarding the physical environment in previous reports. There has been an environmental audit undertaken and there have been some superficial improvements; Laundry storage facilities have been relocated and expanded to address the previously identified problems with personal laundry. The ward has been painted; there are new blinds and bed screens, a mural has been painted in the dining room and there is artwork created by patients around the ward, which resulted from a project with the art therapist. The garden, such as it is, has been improved with artificial grass having been laid, seating provided and murals painted on the walls. However there has been no change to the showers, which remain unsuitable for the majority of the patient group and we are advised that there are structural issues which mean it is not possible to address this.

It is acknowledged by management that the ward facilities and layout remain unsuitable for meeting the needs of the patient group. We are advised that there is a review underway of older adult psychiatry provision across the health board area which will include a review of the estate. We look forward to hearing about the outcome of this.

Recommendation 4:

Managers should ensure the current review delivers an outcome which addresses the provision of an environment that is fit for purpose and supports staff to meet the complex needs of this patient group as a priority.

Summary of recommendations

Recommendation 1:
Managers should, as a priority, review their audit processes to improve the quality of mental health care plans to ensure these are person-centred and updated, to accurately reflect the patient's current needs, planned interventions and legal status.

Recommendation 2:
Managers should, as a matter of urgency, ensure that there is a clear person-centred plan of care for patients who experience stress and distress, which incorporates the information from their Newcastle formulation, where this exists. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation and be regularly reviewed.

Recommendation 3:
Managers should audit section 47 certificates to ensure that consultation with proxy decision makers is recorded.

Recommendation 4:
Managers should ensure the current review delivers an outcome which addresses the provision of an environment that is fit for purpose and supports staff to meet the complex needs of this patient group as a priority.

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.

Claire Lamza
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 Commission 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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

Mental Welfare Commission 2022