Mental Welfare Commission for Scotland

Report on unannounced visit to:

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

Date of visit: 13 December 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 unit providing assessment and treatment for adults who have a diagnosis of dementia. On the day of our visit there were three vacant beds.

We last visited this service on 15 March 2022 and made recommendations relating to person centred care planning, consultation with proxies and the environment.

On the day of this visit we wanted to follow up on the previous recommendations and also to hear how the ward is changing and adapting as restrictions are lifted.

Who we met with

We met with, and reviewed the care of seven patients, six who we met with in person and one who we reviewed the care notes of. We also met with three relatives.

We spoke with the acting senior nurse and the senior charge nurse.

Commission visitors

Mary Leroy, nursing officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

We found completed 'getting to know me' forms in the patients' files we reviewed. This document contains information on an individual's needs, likes and dislikes, personal preferences and background, and it enables staff to understand what is important to the individual and how best to provide person centred care whilst they are in hospital. We also saw 'what matters to me' information above each patient's bed. This is a one page summary of key information about the individual that assists staff to provide care and engage with the individual. This information was reflected in the individual care plans. We found meaningful care plan evaluations that had been updated recently in all but one of the files we reviewed; we were advised by the senior charge nurse of the actions being taken to address this single discrepancy.

There were risk assessments in place for all the patients whose files we reviewed and the identified risks were addressed in the care plans and covered both physical and mental health needs.

A number of the patients whose care we reviewed experienced stress or distress. Where this was the case there was significant variation in the quality of care planning for this. We found Newcastle model formulations in place in patient's files. The Newcastle model 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. In files where detailed formulations had been used, there were person-centred care plans developed for managing the individuals stress and distress. However, in a number of files we found limited formulations and the information in them had not been used to develop a person-centred care plan that set out the possible triggers, stressed behaviours and strategies for managing the patient's distress.

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 audit care plans to ensure that where they are required person centred care plans for stress and distress they are in place.

Care records

Information on patient care and treatment is held in two ways. There was a paper file containing the care plans and care plan reviews, power of attorney and guardianship documentation and section 47 certificates. On the electronic record system EMIS there was correspondence, mental health act paperwork, chronological notes and multidisciplinary team (MDT) review minutes.

MDT and staffing

On site, the unit has a multidisciplinary team (MDT) of nursing staff, psychiatrists, occupational therapy staff, speech and language therapy staff and psychology staff. Referrals can be made to all other services as and when required.

MDT reviews were well documented, with clear actions and outcomes. Proxy decision makers and families were invited to attend MDT reviews and provided with regular updates.

The senior charge nurse post was being filled on an acting basis, with no date set for recruitment to the post on a permanent basis. We heard that the ward has a full complement of registered nursing staff, but, due to a number of health care assistant vacancies, bank and agency staff have had to utilise when there were high levels of clinical activity or observations.

We were told that all of the registered nurses had completed the two-day course on management of stress and distress, and the health care assistants had attended the stress and distress essentials training, which had been beneficial in helping all staff understand and manage their patient's distress more effectively.

Use of mental health and incapacity legislation

On the day of our visit, only two of the 17 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

Part 16 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 corresponded to the medication being prescribed.

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 Act (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 Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found completed section 47 certificates in all of the files we reviewed, and consultation with proxies or next of kin was documented.

Where individuals had granted a power of attorney, or had a guardianship in place, this was recorded and there was evidence that proxy decision makers and families were being invited to MDT reviews and consulted appropriately on decisions in relation to care and treatment. However, in a number of the files we reviewed we were unable to locate a copy of the powers held.

Recommendation 2:
Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are on file.

Rights and restrictions

The ward continues to operate a locked door policy, commensurate with the level of risk to patients. Doors are controlled by a keypad and information on how to access/egress the ward is displayed beside the doors.

We heard that the ward has reverted to unrestricted visiting, with an open visiting policy. We saw visitors arriving in the ward throughout our visit and heard from them that they were made to feel welcome and were encouraged to continue to be involved in their loved ones care.

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 had input from an occupational therapist, a support worker and an occupational therapy technician who provided a range of therapeutic and recreational activities on a one-to-one and group basis. The ward has actively worked towards resuming a range of face-to-face volunteer supports, such as therapet and music therapy. Virtual music sessions via teams were continuing and Music in hospitals were due to attend the ward Christmas party. Whilst the therapet service was fully booked at the time of our visit, they hoped to provide additional capacity in the future. The occupational therapy team continued to provide a range of group and individual activities. There was an activity programme on display in the dining area, and we saw individual activities taking place during our visit. In the chronological notes we reviewed, we saw evidence of a wide range of activities being provided. We heard that the provision of a therapeutic activity nurse post was being explored and look forward to seeing this development on our next visit.

The physical environment

The layout of the ward consists of five single rooms and three shared dormitories. There is a lounge area and a separate dining area for the patients; both are bright and spacious although the sitting area is rather bleak and functional.

On the day of our visit the temperature in a number of the bedroom areas was very cold. We noted this ourselves and it was commented on by relatives and patients. We saw one of the patients walking around with their coat on, and heard that in one dormitory it was so cold that even with additional heaters and blankets being provided, one patient went to bed with all their clothes on. We discussed this with the acting senior nurse, who advised us that the estates department were actively working to rectify the situation and further additional heaters would be arriving that day. We also contacted the service manager to raise our concerns and asked for an update.

We have made recommendations regarding the physical environment in previous reports and there have been some superficial improvements. However there had been no change to the showers, which remained unsuitable for the majority of the patient group. We were advised that there were structural issues which meant that it was not possible to address this. This, compounded by the deficiencies in the heating system meant that this ward is not an acceptable environment to be providing care for vulnerable adults and needs to be addressed as a priority by the hospital management.

Recommendation 3:
The health board needs to take urgent action to address the unacceptable environment.

Summary of recommendations

Recommendation 1:
Managers should audit care plans to ensure that where they are required person centred care plans for stress and distress they are in place.

Recommendation 2:
Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are on file.

Recommendation 3:
The health board needs to take urgent action to address the unacceptable environment.

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.

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