**Mental Welfare Commission for Scotland**

**Report on unannounced visit to:**

Royal Alexandra Hospital, Ward 39, Corsebar Rd, Paisley PA2 9PN

**Date of visit:** 2 August 2023

## Where we visited

Ward 39 is a 20-bedded short-stay ward providing care and treatment for older adults with a functional mental illness. Sleeping accommodation comprised of a number of small dormitories and two single rooms. On the day of our visit, there were 19 patients, four of whom were patients boarded out from adult psychiatric wards.

On our last two visits to the ward, we found there were a number of patients boarded in from adult psychiatry. We had previously commented on the challenges of having high levels of patients boarded in from adult psychiatry, and the implications that this posed for the service. On this visit, we heard that this has remained an ongoing issue due to pressure on beds across the service and that some changes have been made to the way this is managed in the ward. Whereas previously, these patients would have remained under the care of their original consultant, they were now under the care of the staff grade doctor and the adult in-reach team were involved in their discharge planning. We were advised that these changes have improved the care for these patients and reduced the impact on the ward team. However, providing care for such a diverse patient group remained a challenge, compounded by the environmental issues in the ward; there is one communal dining and the sitting area was used by all.

We last visited this service on 22 June 2022 and made recommendations relating to the environment, service capacity, visiting and communication with relatives.

The response we received indicated that the environmental issues were being considered in the bed modelling work that was taking place as part of the review of older adults' mental health services. The other recommendations were being addressed by managers on an ongoing basis.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision and care planning.

## Who we met with

We met with and reviewed the care and treatment of seven patients and spoke with one relative.

We met with the senior charge nurse and charge nurse and contacted the service manager following the visit in relation to our findings.

## Commission visitors

Mary Hattie, nursing officer

Justin McNicholl, social work officer

# What people told us and what we found

## Care, treatment, support and participation

### Nursing care plans

In the patients' records we reviewed, risk assessments were documented and regularly evaluated. Chronological notes were relevant and detailed, providing clear information on each patient's presentation, mental state, and activities.

Care plans were person-centred and addressed identified risks and current needs. Care plan evaluations were regular, thoughtful, and meaningful, however in a number of the records we reviewed the care plan had not been updated to reflect relevant information contained in the evaluation, such as a change in legal status.

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 regularly audit to ensure care plans are updated to reflect any changes in care needs and legal status.

### Multidisciplinary team (MDT) meetings and records

The unit had a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, physiotherapy staff, pharmacy staff and psychology staff. Referrals to other services such as social work, dietetics and speech and language therapy were made as and when required.

It was clear from the MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend and had input to the meetings. This also included the patient and their families, should they have wished to attend. Decisions taken and agreed actions were clearly recorded and this information was reflected in nursing care plan evaluations. Where families did not attend meetings there was evidence of proactive contact to discuss the outcome.

Information on patients care and treatment was held in two ways. There was a paper file that contained the care plans, care plan evaluations, paperwork relating to Adults with Incapacity (Scotland) Act 2000 (AWI), and some risk assessments. The electronic record system, EMIS contained all other documentation including mental health act paperwork, falls and nutrition information, risk assessments, MDT reviews and chronological notes. The ward was using the HEPMA electronic record for medicines management. We heard that work was ongoing with the IT department to ensure that going forward, all information could be saved to the EMIS system.

## Use of mental health and incapacity legislation

On the day of our visit, four patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). All documentation relating to

the Mental Health Act and AWI, including certificates around capacity to consent to treatment, were in place in the paper files and were up-to-date.

The patients we met with during our visit had a good understanding of their detained status where they were subject to detention under 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 (T3s) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed.

In relation to the Adults with Incapacity (Scotland) Act 2000 (AWI Act), where the patient had granted a power of attorney (POA), we found information advising of this and providing contact details for the proxy decision maker. Copies of the powers were available in all the files we reviewed and there was evidence throughout the chronological notes of consultation with proxy decision makers in relation to care and treatment.

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 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 forms in the files of the patients we reviewed who lacked capacity.

## Rights and restrictions

The ward door was secured by a keypad. The code for this was on the wall, next to the door, to enable visitors and patients, who were not subject to restrictions under the Mental Health Act, to leave the ward. The ward conservatory doors were unlocked, and patients were able to access the gardens and grounds freely.

We were told that since our last visit, the arrangements for visiting have changed and there was no longer a requirement to pre-book visits. The ward has an open visiting policy. Due to the limitations of the environment, the majority of visits took place in the communal day dining area, although in fair weather the garden area was also used.

We saw posters advising of the local advocacy service and found evidence in the care records of advocacy services being accessed by 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

The ward had input from an occupational therapist and an occupational therapy assistant, who focused on activity provision. There was an activity timetable on the ward dining room wall with a programme of activities, which included quizzes, exercise, relaxation, tai chi, and a number of other group activities. These were provided by occupational therapy staff, nursing staff and physiotherapy staff. The ward also benefitted from regular art therapy sessions and

some of the artwork was on display. There was a RITA, an all-in-one, touch-screen Reminiscence/Rehabilitation & Interactive Therapy Activities solution, available on the ward, which was used to support both individual and small group digital reminiscence therapy. We saw activity care plans and there was a meaningful recording of activity participation and outcome in the records we reviewed. We saw staff participating in activities on a one-to-one and small group basis during our visit. There was evidence in the records of occupational therapy staff supporting patients to visit their homes and conducting assessments in their home environment.

## The physical environment

We have commented in previous reports on the poor physical environment of the ward. Some work had been undertaken recently, with the provision of an improved kitchen servery area, additional screening in the large room which was used for equipment storage and MDT meetings We also heard that further work was planned to improve the courtyard area, with the provision of raised planters and a shelter to enable patients to use the area more often. However, this does not address the fundamental issue of lack of adequate space and facilities which we have highlighted consistently in previous reports.

The ward has two single rooms and four shared dormitories with up to five beds in each. There was a large lounge and dining area, with an attached conservatory. This was bright and spacious, however as this area was also used for activity provision and visiting, it could be busy and noisy and there was only one other small quiet room which was also used for interviews with patients and relaxation sessions. This means there was little opportunity for patients to find a quiet space away from their peers.

There was still no therapeutic kitchen on site, meaning the occupational therapist have to take patients to their own homes to undertake kitchen assessments. This also limited the team's ability to provide activities such as baking or cooking groups, social lunch, or breakfast groups all of which could be of benefit to the patients in maintaining and developing their self-care and social skills.

There were only two showers, with fixed heads, and one assisted bath available for the twenty patients. We heard from a patient that they were unable to have a shower daily due to there being only one shower available for the eleven female patients. This issue had been commented on by patients and relatives during previous visits.

We remain of the view that the environment is unfit for purpose. We have been told previously that the NHS Greater Glasgow & Clyde are undertaking a review of all older people's mental health services. This will include bed modelling, looking at the standard of patients' facilities, provision of single rooms etc. We have been in contact with senior management asking for information on when this review will be concluded, and an action plan produced.

**Recommendation 2:**
The health board 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 within a reasonable timeframe.

## Summary of recommendations

**Recommendation 1:**
Managers should regularly audit to ensure care plans are updated to reflect any changes in care needs and legal status.

**Recommendation 2:**
The health board 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 within a reasonable timeframe.

## Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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