**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

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

**Date of visit:** 28 February 2024

## Where we visited

Ward 37 Royal Alexandra Hospital is a 20-bedded unit, situated on a District General Hospital site, providing assessment and treatment for older adults with dementia from East Renfrew and Renfrewshire.

On the day of our visit, there were no vacant beds.

We last visited this service in December 2022 and made recommendations relating to the environment, care planning and proxy decision makers.

The response we received from the service was that these issues were being addressed; audits were being carried out regularly and staff training had been provided. Regarding the environment there is a review of older adults' mental health provision across the health board area; the outcome of this will address the issues of accommodation in the longer term.

Meanwhile the ward had been decanted for a period of several months to allow for the installation of a new heating and water system, returning to its current location in December 2023 once this was completed.

On the day of this visit, we wanted to follow up on the previous recommendations and to hear about activities and communication with relatives.

## Who we met with

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

We spoke with the service manager, the senior charge nurse, charge nurse and consultant psychiatrist. We also met with the occupational therapist and practice development nurse.

## Commission visitors

Mary Hattie, nursing officer

Douglas Seath, nursing officer

## What people told us and what we found

The relatives we met with spoke positively about the permanent staff team, saying they generally found them welcoming and helpful, and that their relatives were well cared for. They commented that though the nursing care could not be faulted, the nurses all seemed to be exceptionally busy, and a number did express concern that there are often staff on duty who were unfamiliar with the ward and the individuals being cared for.

Several of the relatives we spoke with held power of attorney (POA). We asked whether they felt involved and consulted regarding their relatives' care; for instance, were they invited to attend or contribute their views to multidisciplinary team (MDT) meetings. The majority of the relatives we spoke with had not been invited to the MDT meetings, nor were they being asked for their views in advance or receiving feedback.

From our discussions it also became clear that, whilst POAs were informed of changes to their relatives' treatment, such as being commenced on antibiotics after it had occurred, they were not being appropriately consulted and their consent was not sought at the time. Several relatives also advised us that in the fortnight prior to our visit they had been approached by staff and asked to sign documents such as section 47 certificates or care plans, to indicate they had been consulted, when in fact the documents had been completed by staff some months previously, without them having been consulted or informed.

It is essential that proxy decision makers are involved and consulted appropriately regarding decisions around care and treatment. Informing them retrospectively is not in keeping with the legislation and is not acceptable. A system needs to be in place to ensure appropriate consultation and involvement in decisions takes place and is recorded.

All of the relatives we met with told us about difficulties with the laundry system, with significant amounts of clothing going missing over recent months. The staff advised us that there have been ongoing problems, with the personal laundry service, with machines being out of service for around six weeks, resulting in a significant backlog and delays in items being returned. We were told his had been so bad that staff on night shift were taking laundry by taxi to another hospital, which had a ward-based machine, and were washing it themselves. We were told that the machines are supposed to be back in service this week and the situation should improve.

Staff also told us that previously there was a system in place for relatives who wished to take laundry home to wash. Each wardrobe was lockable and had a drawer where dirty laundry was stored for collection by the family. However, the majority of the locks were damaged in transit following the decant of the ward. This has resulted in an increase in clothing going missing, as confused people may pick up other patients clothing. As a result, a bid is being submitted for new furniture to ensure clothing can be securely stored.

We were concerned to hear about the inadequate laundry service and expect this to be resolved as soon as possible. The concerns highlighted to us were discussed with the service manager and senior charge nurse on the day.

## Care, treatment, support and participation

### Care records

Information on care and treatment was held in three ways; there was a paper file, the electronic record system EMIS and the electronic medication management system. The health board is in the process of transitioning across to a fully electronic system. Copies of POAs, guardianships and care plans are currently held in the paper system. MDT reviews and chronological notes were held on EMIS along with Mental Health Act paperwork.

We found completed Getting to Know Me documentation in all of the files we reviewed, and What Matters to Me forms at bed areas. This is a one-page summary of key information about the individual that assists staff to provide care and engage with the individual. Care plans varied considerably in quality. The majority of the care plans we reviewed lacked person-centred information, were completed shortly after admission and had not been updated to reflect changes in each individual's presentation or care needs, despite these being documented in care plan evaluations and chronological notes. Whilst risk assessments had been completed for the people we reviewed, not all risks that had been identified were addressed in the care plans.

We had previously made a recommendation in relation to care planning for stress and distress. In a number of the files we reviewed, we found that the individual did experience stress and distress, however we did not find person-centred care plans for the management of this, or with the setting out of information on individual triggers and strategies for managing this, despite, in some cases, a Newcastle formulation having been completed. The Newcastle model is a framework and process, developed to help nursing and care staff understand and improve their care for people who may present with behaviours that challenge.

**Recommendation 1:**
Managers should ensure nurses are provided with education on person-centred care planning and ensure nursing care plans are person centred, address all identified risks and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.

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

In the files we reviewed, we found two DNACPR forms which did not record any consultation with the proxy decision maker. The Scottish Government produced a revised policy on DNACPR in 2016 (http://www.gov.scot/Resource/0050/00504976.pdf). This makes it clear that where an adult cannot consent and there is a guardian or welfare attorney with the relevant powers, the guardian or attorney must participate in any advance decision to give, or to not give, CPR. Where there is no guardian or attorney for a person who cannot consent to a decision about CPR, it is a requirement to consult with the close family, as well as taking what steps are possible to establish the wishes of the person. In all cases, this involvement or consultation should be recorded.

**Recommendation 2:**
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

### Multidisciplinary team (MDT)

The unit has a multidisciplinary team of nursing staff, psychiatrists, occupational therapy staff, a physiotherapist 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. In the notes we reviewed, we could not find evidence of proxy decision makers, or of families attending MDT reviews, or of any structured feedback from these meetings; however we found a number of letters inviting relatives to upcoming MDTs.

**Recommendation 3:**
Managers should ensure that relatives are given the opportunity to attend or otherwise contribute their views to MDT reviews and should put in place a system for providing feedback where relatives do not attend.

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 number of registered nursing staff vacancies, and this combined with staff absence results in bank staff having to be utilised when there are high levels of clinical activity or observations.

## Use of mental health and incapacity legislation

On the day of the visit, five people were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). All documentation relating to the Mental Health Act was in place.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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.

All patients were under the Adults with Incapacity (Scotland) Act 2000 (the AWIA).

Where the individual had granted a power of attorney (POA) or was subject to guardianship order under the AWIA, 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.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. However, a number of s47 certificates that we reviewed, either had not been completed to confirm the proxy decision maker had been consulted, or where the proxy had signed the form this had been done several weeks after the form had been completed by medical staff.

**Recommendation 4:**
Managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted and their consent sought; the manager must ensure that this process and outcome is clearly recorded.

Where covert medication was in place, all appropriate documentation was in order.

## Rights and restrictions

The ward continues to operate a locked door policy, commensurate with the level of risk. 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 implemented person-centred visiting, and observed leaflets advising of this were available at the ward entrance. 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 one's care.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that people 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.

The occupational therapy team continued to provide a range of group and individual activities including using reminiscence boxes provided by Glasgow Museums. There was an activity programme on display in the dining area. In the chronological notes we reviewed, we saw evidence of activities being provided.

## The physical environment

The Commission has made recommendations in relation to the poor physical environment of Ward 37 over a number of years. Our last report made special mention of the temperature of the ward and the unsuitable shower facilities. We were therefore pleased to find that following a recent decant, a new heating system and water system had been installed and the showers, whilst no longer anti ligature compliant, were suitable for the care needs of the people in the ward. Staff told us that the new system has made a significant improvement to the temperature on the ward.

We heard from the service manager that the older adult's mental health service review, which includes a review of the inpatient provision, is progressing to public consultation over the next few months and it is hoped this will report in the autumn.

The layout of the ward consists of five single en-suite rooms, and three, five bed dormitories. Toilets are well signposted and dementia friendly. There is an activity room, used by

occupational therapy for small group activities, a dining room and a large sitting room with conservatory attached, from which the ward garden can be accessed.

Whilst both sitting and dining rooms are large and bright, there is little to provide stimulation in the environment. In the sitting room the furniture is very institutional and is arranged in rows facing the television. In the dining room there is a large activity timetable. Visitors use the dining room or individual bedrooms for visits.

The ward is some distance from the main hospital or any local facilities such as shops or cafes. Relatives commented to us that due to this and limited parking on site, it is difficult to take their loved one off the ward during visits.

The garden space is limited to a long and narrow stretch, bordered on one side of the ward and on the other by a wall and high bank. The area is secure, and work has been done to make it as pleasant as possible with murals on the wall, several benches and chairs, and flower beds.

We found posters advising of our visit in the entrance to the ward along with information about the local advocacy service.

Despite the improvements which have been made since our last visit it remains our view that the ward is not a suitable environment in which to provide care to the current patient group. We look forward to hearing about the outcome of the older adults' review, and how it will impact on the ward at our next visit.

## Summary of recommendations

**Recommendation 1:**
Managers should ensure nurses are provided with education and support on person centred care planning and ensure nursing care plans are person centred, address all identified risks and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.

**Recommendation 2:**
Managers should ensure an audit of all DNACPR forms to ensure that, where relevant, all welfare guardians/powers of attorney have been consulted and their opinion recorded.

**Recommendation 3:**
Managers should ensure that relatives are given the opportunity to attend or otherwise contribute their views to MDT reviews and should put in place a system for providing feedback where relatives do not attend.

**Recommendation 4:**
Managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted, and their consent sought; the manager must ensure that this process and outcome is clearly recorded**.**

## Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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

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