Mental Welfare Commission for Scotland

Report on announced visit to: Ward 37, Royal Alexandra Hospital, Corsebar Road, Paisley PA2 9PN

Date of visit: 8 January 2018

Where we visited

Ward 37 is a short stay 20-bedded ward providing psychiatric assessment and care for people with dementia. We last visited this service on 13 January 2016 and made recommendations.

The recommendations made, were focussed on two main areas. A number of recommendations were made about improving the environment to make it more dementia friendly. We also recommended that care plans be reviewed regularly and reflect the individuals life history and personal preferences, and where necessary care plans addressed the management of stress and distress.

On the day of this visit, we wanted to follow up on the previous recommendations and also look at use of the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

Who we met with

We met with and/or reviewed the care and treatment of seven patients/residents and had telephone interviews with two carers/relatives/friends following the visit.

We spoke with the senior charge nurse and charge nurse, the occupational therapist (OT) and the physiotherapist.

Commission visitors

Mike Diamond, Executive Director (Social Work)

Mary Hattie, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We had previously made recommendations in relation to life history information, person-centred care planning and the management of stress and distress. We found 'getting to know me' documentation completed within some files we reviewed. In others, it was noted this was with relatives for completion. We also found information on 'what is important to me' beside each patient's bed. The care plans we saw were person-centred and reviewed regularly.

One relative we spoke to advised us that her relative was very distressed by being in a mixed-sex environment. There were issues with men walking into the female bed bay and rooms, and her mother didn't feel safe because of this. We discussed this with staff and they advised that, whilst every attempt is made to protect the privacy and dignity of all patients and ensure they feel safe, it is not always possible to prevent confused male patients entering the female area.

The ward has regular input from a clinical psychologist who works with families who are struggling to deal with the diagnosis of dementia, and with patients who are experiencing stress and distress. One of the nurses has completed their diploma in cognitive behavioural therapy (CBT) and has undergone the NHS Education for Scotland (NES) trainers' course in managing stress and distress. We saw evidence of the Newcastle model for managing stress and distress being used in the formulation of care plans for stress and distress.

The ward has regular input from OT and physiotherapy and can access other allied health professional (AHP) and specialist services as required. Two ward nurses have recently completed tissue viability training, so this expertise is now available in house.

Social work input is provided by the hospital social work department who attend multidisciplinary team (MDT) meetings on a regular basis.

We heard that two staff are undertaking training in symptom assessment and management and undertaking a four day course in palliative care at the local hospice, and all nursing assistants will undertake three days training in palliative care this year.

MDT meeting notes were clear and details of changes to care and decisions made were recorded. However, there was inconsistency in recording who attended the meeting.

Recommendation 1:

Managers should review the environment and supervision arrangements to ensure that the privacy and dignity of vulnerable patients is protected and that they feel safe within the ward environment.

Recommendation 2:

Managers should ensure that MDT notes include a record of who attended the meeting.

Use of mental health and incapacity legislation

We found that where individuals were subject to power of attorney (POA) or welfare guardianship, this was recorded within their file and copies of the powers were available. However, these were not consistently filed within the legislation section of the live care file, but in some cases held in the medical record. One relative we spoke to commented that, despite having POA with medical powers, they were not consulted or advised of new treatment being commenced. We followed this up on the day.

All files we reviewed contained appropriate s47 certificates and treatment plans, and recorded consultation with relatives or proxy decision makers.

On the day of our visit, six patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. Four were on compulsory treatment orders and two

on short term detentions. Where patients were subject to the Mental Health Act, there was a care plan for this and, where required, a consent to treatment certificate (T2) or certificate authorising treatment (T3) was in place within the drug prescription sheet covering all treatment. However, copies of the relevant detention papers were not consistently available within the legislation section of the live care file, but were in some cases held within the case notes.

Recommendation 3:

Managers should ensure that copies of proxy powers and mental health act detention paperwork are filed consistently within the legislation section of the live care file to ensure that staff have ready access to these.

Rights and restrictions

Due to the need to ensure the safety of the patient group the ward door is locked, with a keypad entry and exit system. Where patients were noted to be actively seeking to leave the ward, the need for detention under the act was reviewed.

Activity and occupation

We were advised that, although there is not an activities co-ordinator within the ward, the OT is trained in cognitive stimulation and, along with the technical instructor, provides an activities programme which includes Therapet sessions fortnightly, musical memories singing sessions, football memories and reminiscence sessions, as well as lunch groups and coffee mornings. We found evidence of participation in the OT led activity programme in the notes we reviewed. However, one relative we spoke with felt that there was not enough stimulation available and that, due to staffing levels, patients who chose not to sit in the sitting room were often left with little supervision.

We were told that a number of iPads have been purchased and, once their use has been approved by hospital management, these will be used to enable staff to undertake one-to-one activity sessions with patients. We look forward to seeing the impact of these on our next visit.

The physical environment

There is appropriate dementia signage throughout the ward and, following a dementia audit, the ward now benefits from orientation aids and has been repainted using contrasting colours for handrails, etc. However the basin taps and the showers are not suitable for the client group. Taps are long-levered taps for elbow operation and staff advise us they are often left on by patients, as they are unsure how to turn them off, leading to flooding. The showers are fixed-head, time-limited push-button showers, such as those found in sports facilities. These are not suitable for this patient group.

Recommendation 4:

Managers should ensure that the current inappropriate showers and basin taps are replaced.

Summary of recommendations

1. Managers should review the environment and supervision arrangements to ensure that the privacy and dignity of vulnerable patients is protected and that they feel safe within the ward environment.

2. Managers should ensure that MDT notes include a record of who attended the meeting.

3. Managers should ensure that copies of proxy powers and mental health act detention paperwork are filed consistently within the legislation section of the live care file to ensure that staff have ready access to these.

4. Managers should ensure that the current inappropriate showers and basin taps are replaced.

Good practice

We noted that the ward is using the PRN (‘as required’ medication) alert yellow sticker system and is consistently recording the patient’s response to PRN medication when this is given.

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

Mike Diamond
Executive Director (social work)

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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