Mental Welfare Commission for Scotland

Report on announced visit to: Ward 39 Royal Alexandra Hospital, Coresbar Road, Paisley PA2 9PN

Date of visit: 20 November 2017

Where we visited

Ward 39 is a 20-bedded short stay ward, providing a service predominantly for individuals with a functional mental illness. The ward is situated within Royal Alexandra Hospital. We last visited Ward 39 in January 2016 as an announced visit, and we made recommendations about care planning, activities 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 reviewed the care and treatment of seven patients.

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

Commission visitors

Mary Leroy, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

There was a calm atmosphere within the ward, staff were interacting with patients in a warm and respectful way. A patient we met with was on enhanced observation and he commented, he was always treated with 'dignity and respect', and we saw evidence of regular review ensuring he received care in the least restrictive way possible.

We observed completion of 'Getting to know me' life histories. This documentation was completed by the patients' families. We also saw 'subjective assessments' (an assessment completed by the patient) seeking their views on the reason for admission to hospital, their main concerns, and what would improve their stay in hospital. Within the files, we looked at if life histories and subjective assessment where used to inform the initial assessment and the patients' care plan.

We were informed by the SCN, of the monthly care audit of care plans and input from the practice development nurse to improve on care planning. On review of the care plans we saw on the day, we were pleased to see improvements in practice.

The nursing care plans were in four areas: mental health, physical health, legal aspects, family and carer. The care plans were person centred and recovery focussed. The care plans were reviewed on a regular basis, however the information about changes to the patient's presentation, or care needs, were not always incorporated into the current care plan.

Risk assessments and safety plans gave a clear history of risk, and identified triggers and coping strategies were within the supporting action plan. The risk assessment and safety plan were updated and reviewed on a regular basis. The OT and community psychiatric nurse are also involved in a thorough assessment of risk within the community setting, prior to the patient's discharge home.

On our last visit to the service, we had made a recommendation regarding stress and distress care planning. The SCN informed us that the ward psychologist is leading on staff education and training in relation to this. The plan is to train two senior members of staff, who will then assist with cascading the training to the ward team.

We were advised that pharmacy is regularly available and the pharmacist reviews the patient's prescription sheets on a regular basis.

There are five consultants on the ward. Patients are encouraged to attend multidisciplinary team (MDT) meetings, however many patients meet with the respective consultant for an update following the meeting. The clinical discussions that occur within the MDT are well documented and generate a clear action plan with treatment goals. The MDT meeting and chronological notes evidenced a multi professional approach to care with contributions from medical staff, nursing staff and allied health professionals. When planning for the patient's discharge, the team work flexibly to ensure a seamless, supported, discharge plan. The SCN comments that most of the patients, if possible, return to their own homes. We were informed that social work have regular contact with the ward and attend the MDT meetings

Staff informed us of regular contact with families and carers. Telephone calls and conversations with families and relatives were documented in the patient's files. There was also evidence of a family member assisting with some aspects of the patient's care.

There was good attention to physical health care needs, full physical examination on admission to the ward, and routine physical health monitoring bloods, vital signs, weight and referral to specialised services if required.

Recommendation 1:

The SCN should undertake an audit of care plans to ensure consistency following review that care plans are updated to reflect the relevant changes (to patients' presentation and care needs?).

Use of mental health and incapacity legislation

Copies of certificates authorising detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 were in patients' notes**.**

We examined drug prescription sheet and treatment certificates (T2/3) in place for all patients who required them. They were filed with the patients medication chart, enabling easy checking and reference to be made.

Adults with Incapacity (Scotland) 2000 s47 consent to treatment authorisations were in order along with accompanying care plans.

Rights and restrictions

The SCN discussed the changing 'patient profile' describing an increase in patients presenting with cognitive impairment. The ward has an open door policy. We discussed that the service may want to review this policy, and consider the use of telecare and assistive technology for people with dementia.

The Commission have published good practice guidelines which may assist with this issue:

Rights risks limits to freedom

This publication cannot give definitive guidance, but it can assist and help staff think about, should they consider, a locked door policy. Ensuring that staff think about their actions and the impact their actions may have on individuals they are caring for. The guidance set out a number of general principles the Commission believe need to apply to the locked door policy in any setting. When using this good practice guidelines, the staff should also consider the National Care Standards and the Dementia Standards.

Decisions about technology

Principles and guidance on good practice when considering the use of telecare and assistive technology for people with dementia, learning disability and related disorders.

Activity and occupation

The daily activity programme was displayed prominently on the ward. We found in the chronological notes, evidence of patient participation in activities, delivered either on a one-to-one basis or in a group.

We met with the ward OT and the physiotherapist who discussed activities, and therapeutic work that was available for patients. We found a good range of activities including, skill building physical exercises, walking and access to the gym equipment, art and craft and relaxation. The ward also has input from a visiting music therapist. We heard that when staffing allowed, the nursing team also provided some social activities for the patients.

The physical environment

The ward has been adapted from a general hospital ward. The ward has one sitting room, a dining room and a conservatory. There appears to be a lack of storage space,

resulting in hoists and other equipment being stored within communal and corridor areas. This makes the ward look cluttered, and poses a risk to patients and staff.

Most of the beds within the dormitories, have a large window on the corridor and the outside, giving little privacy. There is dementia friendly signage on the toilets.

We were pleased to see that the admin office is no longer within the ward environment. Staff told us of plans to refurbish the room, with an OT kitchen, to allow patients to be assessed and also to maintain life skills.

We were told of the ward refurbishment, and that two showers had been installed. We were told by staff that the rails around the shower were not collapsible, and the original plans were for the shower rails to be collapsible and ligature safe. The SCN has escalated this to her senior managers to raise this concern. We commented that this should be attended to as a matter of urgency.

Summary of recommendations

1. The senior charge nurse should undertake an audit of the care plan to ensure consistency following review that the care plan is updated to reflect the relevant changes.

Service response to recommendations

The Commission requires a response to this recommendation 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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