

Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 37, Royal Alexandra Hospital, Corsbar Rd, Paisley, PA2 9PN

Date of visit: 9 April 2019

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 8 January 2018 and made recommendations relating to the environment, recording of multidisciplinary meetings, and legal paperwork.

On the day of this visit we wanted to follow up on the previous recommendations and also look at activity provision. This is because this is an important part of dementia care, and on our previous visit we were advised that the ward was about to implement the use of iPads with patients as a tool to improve communication and stimulation.

Who we met with

We met with and or reviewed the care and treatment of nine patients.

We spoke with the charge nurse and staff nurses, and the occupational therapist.

Commission visitors

Mary Hattie, Nursing Officer,

Anne Buchanan, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

The ward has regular input from occupational therapy, physiotherapy and psychology. Additional input from allied health professionals and specialist services can be sought by referral. There are three consultant psychiatrist attached to this ward.

There is dedicated clinical psychology input, and one of the charge nurses has completed the NHS Education for Scotland trainer's course for managing stress and distress. However, within the patients' files we reviewed, there were no care plans for the management of stress and distress despite some patients being prescribed 'as required' medication for agitation. Chronological notes further identified incidents of stressed and distressed behaviours for one patient who had been referred to a specialist violence reduction team. However, following this referral, there was no evidence to suggest what the outcome had been.

There was evidence of regular reviews of care plans, however the care plan was not updated to reflect the outcome of the review.

The majority of patients whose care we reviewed did not have a completed 'Getting to Know Me' on file. This is a document which records a person's needs, likes and dislikes, personal preferences, and background, and is aimed at helping hospital staff understand more about the person, and how best to provide person-centred care

during a hospital stay. Furthermore there was little evidence of life story information being recorded. As most patients will move on to further care placements it is important that this information is recorded and goes with them through their care journey

Recommendation 1:

Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation, and be regularly reviewed.

Recommendation 2:

Managers should ensure care plans are evaluated and updated to reflect changes to the patients' needs and the effectiveness of interventions.

Recommendation 3:

Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement.

The Mental Welfare Commission and Care Commission joint report on the quality of care for people with dementia living in care homes in Scotland can be found here:

[Remember I'm Still Me report](#)

Use of mental health and incapacity legislation

Within the files of the patients we reviewed, who we had been told were subject to Mental Health (Care and Treatment) (Scotland) Act 2003 legislation, ('the Mental Health Act'), recording sheets were not completed and we could not find copies of current detention papers. On further investigation, we found that two of these patients were no longer subject to the Mental Health Act, as their detention had been allowed to lapse some time ago. However, nursing staff were unaware of this.

Part 16 (s235-s248) 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.

We found that one patient was being given treatment which was not covered by the T3 certificate in place to authorise their medication. We found that another patient's treatment was authorised by a T2 certificate indicating they had capacity to consent to treatment for their mental disorder, but they were also receiving treatment for their physical health under section 47 of the Adults with Incapacity Act (Scotland) 2000 ('the AWI Act), indicating they did not have capacity to consent to their treatment. We asked that the consultant responsible review both these patients and take the steps necessary to ensure their treatment was appropriately authorised.

Section 47 of the AWI Act authorises medical treatment for people who are unable to give or refuse consent. Under s47 a doctor (or another healthcare professional who has undertaken the specific training) examines the person and issues a certificate of incapacity.

We found s47 certificates in place for the patients whose files we reviewed, authorising their treatment under the AWI Act. We could not find any record of the granting of the certificate having been discussed with their family or, where one existed, their proxy decision maker.

Recommendation 4:

Managers should ensure that copies of current detention papers are held in patients' care files, and the Mental Health Act recording sheet is completed to provide an accurate record of the date of commencement and expiry of detention.

Recommendation 5

Managers should ensure that where a proxy 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.

Recommendation 6

Managers should audit drug prescription sheets to ensure that all treatment is properly authorised under either the Mental Health Act or AWI legislation.

Rights and restrictions

Entry and exit from the ward is controlled by staff via a keypad system to maintain patient safety. There are notices advising visitors to wait for staff to let them in and out of the ward. However, due to the proliferation of notices on the wall around the entry buzzer, it was difficult to find the buzzer to request entry.

There were notices within the corridor advising that advocacy services were available and giving contact details. Staff advise that advocacy workers visit regularly and respond promptly to referrals.

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/rights-in-mind/>

Activity and occupation

The ward has a full time occupational therapist and a technical instructor who works across Wards 37 and 39. They provide an activities programme which includes therapet sessions, musical memories singing sessions, football memories, and reminiscence sessions, with reminiscence boxes provided by the local museum service, as well as lunch groups and coffee mornings. We found evidence of participation in these activities recorded within the notes. However, there was no recording of any other activity participation with the notes we reviewed, and no activity care plans.

On our previous visit we were advised that iPads had been purchased for use with the patients to increase opportunities for reminiscence, recreation and communication. We are advised by staff that the iPads are still in storage, due to data protection issues and lack of agreed protocols for their use.

Recommendation 7:

Managers should ensure that patients have activity care plans which are person centred, reflecting the individual's preferences and activities specific to their care needs, and that participation in activities is recorded.

The physical environment

We previously made recommendations about the washing facilities within patients' bedrooms. While they meet Hospital Acquired Infection and anti-ligature standards, they do not meet the needs for frail and confused older adult patients. Staff report that it is impossible to assist a patient to wash without becoming wet themselves, and patients are often confused by the need to push the button regularly to ensure the shower stays on. Staff report that there are frequent flood/overflow issues when patients are unable to operate the long lever elbow taps provided in bedrooms. This issue needs to be escalated to senior management for action. Furthermore, there was an odour of urine in several rooms

The ward offers communal areas for patients however the decor was dismal. Patients' bedrooms, dining room and sitting rooms appear to have been particularly neglected. For example, where signage had been removed and had not been replaced. There are no pictures or artwork anywhere within the ward which had the effect of making the ward look desolate and lacking in any warmth. In the dining room the orientation calendar had not been updated for several days. We saw curtains around bed areas which were either missing or needing re-hung. We were advised by staff this had not been attended to by the estates department, despite having being reported. The ward's garden, which on previous visits was a pleasant well used area, looked neglected. We were advised by staff that there had been difficulties securing support from the estates department to maintain this area.

There is a pleasant conservatory, which we are advised is well used.

The layout of the ward, with several dormitories and a small number of single rooms, is not suitable for the patient group. We saw disorientated male patients entering female dormitory areas several times during the day. We were advised by staff that there are ongoing issues with males and females entering each other's dormitories which causes distress and has the potential to compromise patient's dignity. This issue was the subject of a recommendation in our last report and needs to be escalated to senior management for action.

Although there were memory boxes beside each bed, there was very little personalisation of bed areas to assist orientation for confused patients. However, the wipe boards with information on 'what is important to me' above each bed were populated with useful information to enable staff to engage with patients and provide person centred care.

The activity room, which is used by occupational therapy, is small. We are advised that this limits activities offered as it cannot accommodate groups of more than six patients. There is no therapeutic kitchen on site, meaning that when patients require a kitchen assessment they either have to be transported to Dykebar Hospital, or taken to their own home, which can cause confusion and distress when they are required to leave to return to hospital.

There are numerous notices in the entry to and around the ward, many of which are significantly out of date. Most of these are not relevant for patients and carers. Those notices we did see which were for visitors were instructions such as: "visit only in designated area"; "no photographs", and "dispose of your rubbish". These did not contribute to a welcoming environment;

Recommendation 8:

Managers should undertake a detailed dementia-friendly environmental audit and develop an action plan to address the issues highlighted.

Summary of recommendations

1. Managers should ensure that there is a clear person-centred plan of care for patients who experience stress and distress. This should include information on the individual's triggers and strategies which are known to be effective for distraction and de-escalation, and be regularly reviewed.
2. Managers should ensure care plans are evaluated and updated to reflect changes to the patients' needs and the effectiveness of interventions.
3. Managers should ensure that life history information is recorded and follows the patient when they move to a further care placement.

4. Managers should ensure that copies of current detention papers are held in patients' care files, and the Mental Health Act recording sheet is completed to provide an accurate record of the date of commencement and expiry of detention.
5. Managers should ensure that where a proxy 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.
6. Managers should audit drug prescription sheets to ensure that all treatment is properly authorised under either the Mental Health Act or AWI legislation.
7. Managers should ensure that patients have activity care plans which are person centred, reflecting the individual's preferences and activities specific to their care needs, and that participation in activities is recorded.
8. Managers should undertake a detailed dementia-friendly environmental audit and develop an action plan to address the issues highlighted.

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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