**Mental Welfare Commission for Scotland**

**Report on announced visit to:**
Royal Alexandra Hospital, Wards 37 and 39, Corsebar Road, Paisley PA2 9PJ

**Date of visit:** 19 December 2024

## Where we visited

Wards 37 and 39 are both 20-bedded units situated on the District General Hospital site. The catchment area is East Renfrew and Renfrewshire. Ward 37 provides assessment and treatment for older adults with Dementia and organic illness. Ward 39 provides assessment and treatment for older adults with a functional illness.

On the day of our visit, there were 18 patients in Ward 37 and 20 in Ward 39 number; three of the patients in Ward 39 were boarding in from adult services. We were assured that these patients were appropriately placed and that the systems in place ensured their care needs were able to be fully met. The senior charge nurse advised that they were fully consulted regarding any transfers in.

We last visited this service in August 2023 and February 2024 and made recommendations for Ward 39 on the need to ensure care plans were updated to reflect changes in presentation, and on the environment. In Ward 37, we made recommendations on the quality of care planning, and the need to consult with families and obtain consent from proxy decision makers.  The response we received from both wards indicated that the issues were being addressed.

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

### Who we met with

We met with and reviewed the care of 12 people, 10 who we met with in person and two who we reviewed the care notes of. We also spoke with six relatives.

We spoke with the service manager, the senior charge nurse, the charge nurse, the operational lead nurse, lead nurse support and the occupational therapist.

### Commission visitors

Mary Hattie, nursing officer

Justin McNicholl, social work officer

Anne Craig, social work officer

Paul Mcquire, nursing officer

## What people told us and what we found

We spoke with a number of individuals and relatives across both wards. The majority of relatives that we met with spoke positively about the permanent staff team saying, generally, they found them welcoming and helpful, and that their relatives were well cared for.

As on previous visits, we heard that the nurses all seemed to be exceptionally busy. This was echoed by the individuals we spoke to who told us “this place is understaffed at all times” and “there are too many people in here. I struggle with staff. I have to shout to get care. I don't see the doctor regularly and he always says they are too busy.”

Some patients in Ward 37 raised concerns about supervision in the ward and the availability of staff. We heard “it can be a frightening environment. There are occasions when men go into our toilets and they are all unsupervised around the ward when clearly they should be having support. I do raise issues when I can with staff."

Several of the relatives we spoke with held power of attorney (POA). The majority of people we spoke with told us they were being consulted and consent was being sought for changes to treatment. However, this was not universal, with some POA’s of people in Ward 37 telling us they experienced difficultly on obtaining information and were being advised of medication changes rather than consulted in advance.

We heard from relatives in Ward 37 that they had only been asked to complete the Getting To Know Me documentation in the last fortnight and were advised by others that their relatives What Matters to Me information had only been completed in the last 24 hours, despite their relative having been in the ward for some months. These documents provide information on individual’s preferences, needs and life history that would assist staff in providing person-centred care.

We heard from several relatives that in Ward 37, there were issues with clothing being lost, and their relative being dressed in other peoples clothing, which they found distressing.

## Care, treatment, support, and participation

### Care records

Both wards had migrated much of the information previously held in paper files to the electronic records system EMIS. POA documentation, section 47 paperwork and care plans were now held electronically.

In the records we reviewed in Ward 39, risk assessments were documented and regularly evaluated. Chronological notes were relevant and detailed, providing clear information on each person's presentation, mental state, and activities.

Care plans were of a high standard. They were detailed, person-centred, holistic and addressed identified risks and current needs. Care plan evaluations were regular, thoughtful, and meaningful, and care plans were updated to reflect changes in presentation.

In Ward 37 it was difficult to identify the most recent care plan version due to variations in how these were saved, the current care plan did not necessarily show as the most recently saved plan. Care plans varied considerably in quality. The majority of the care plans we reviewed lacked person-centred information and had not been updated to reflect changes in presentation or needs, despite this being contained in the regular and meaningful care plan reviews and in chronological notes.

**Recommendation 1:**
For Ward 37, managers should put a system in place to ensure that the most recent version of the care plan is readily identified.

We had previously made a recommendation in relation to care planning for stress and distress. In several of the records that 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 2:**
For Ward 37, managers should ensure nursing care plans are person-centred and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.

While risk assessments had been completed for the people we reviewed, we found that these were out-of-date, with earlier versions being repeated rather than meaningfully reviewed to reflect changes.

**Recommendation 3:**
For Ward 37, managers should ensure that risk assessments are reviewed on a regular basis.

Completion of Getting to Know Me documentation was inconsistent, with several people not having this important information completed, and others containing very limited information. This document contains information on an individual's needs, likes and dislikes, personal preferences and background, to enable staff to understand what is important to the individual and how best to provide person centred care whilst they are in hospital. As many will move on to further care placements, it is important that this information, along with more detailed life history information, is recorded and goes with them through their care journey.

**Recommendation 4:**
For Ward 37, managers should regularly audit the Getting to Know Me documentation to ensure this is fully completed and life history information is recorded and follows the patient when they move to a further care placement.

The Commission has published a good practice guide on care plans[1]. 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.

**Multidisciplinary team (MDT)**
Both wards were served by a multidisciplinary team of nursing staff, psychiatrists, occupational therapy staff, pharmacy staff, a physiotherapist and psychology staff. Referrals could be made to all other services as and when required.

We heard that the wards had successfully recruited a number of registered nurses and were almost at full complement, for the first time in some time; further recruitment was also underway.

In both wards, MDT reviews were well documented, with clear actions and outcomes. In Ward 39, there was evidence of relatives and proxies being invited to attend MDTs and where families did not attend meetings, there was evidence of proactive contact to discuss the outcomes.

In Ward 37, we saw evidence of a number of relatives attending MDT reviews, however, where they did not attend there was a lack of evidence of proactive contact in seeking their views or to discuss decisions that had been made; this was consistent with what we heard from relatives. Whilst it was clear from the files we reviewed that there has been progress made in relation to relative engagement in Ward 37, this remained a work in progress. We were reassured by our discussions with managers that work was ongoing to address this issue, and we look forward to seeing further progress in relation to this on our next visit.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

## Use of mental health and incapacity legislation

On the day of the visit, 13 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 and up-to-date.

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 (T3s) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

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 (the AWI 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. In both wards we found section 47 certificates in place where these were required. However, in Ward 37, we found a number of section 47 certificates that did not indicate that the proxy had been consulted, where there was a known proxy in place. On speaking to at least one of these proxies, they were being appropriately consulted.

**Recommendation 5:**
For Ward 37, managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted and this process clearly recorded.

For individuals who had covert medication in place, all appropriate documentation was in order.

## Rights and restrictions

In both wards, the doors were controlled by a keypad, commensurate with the level of risk. Information on how to access/egress the ward was displayed beside the doors.

Both wards have an open visiting policy. Due to the limitations of the environment, the majority of visits take place in the communal day dining area or at the individuals bedside.

We saw posters advising of the local advocacy service and found evidence of this service being accessed in the care records of those individuals who we reviewed.

The Commission has developed *Rights in Mind.*[2] 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.

## Activity and occupation

Both wards had input from an occupational therapist and an occupational therapy assistant who focused on activity provision.

There was a regular programme of activities, displayed in each ward. This included quizzes, exercise, relaxation and a number of other group activities. The wards also benefitted from regular art therapy sessions, therapet sessions and music sessions, which were provided by a wandering minstrel, who we were advised is about to retire. We look forward to hearing how this resource is replaced during our future visits.

The occupational therapist told us that as well as small groups, activities were also undertaken on a one-to-one basis where this more suited an individual's needs. We heard that they utilise reminiscence boxes provided by Glasgow Museums.

The occupational therapist also spoke about their role in supporting individuals to visit their homes and conducting assessments in their home environment. We were able to observe a Christmas decoration programme that was being run by the occupational therapist and art therapist which was delivering positive outcomes for the individuals who participated.

In the chronological notes we reviewed, there was meaningful recording of activity participation and outcome.

## The physical environment

Both wards comprised of a number of single rooms and dormitories that held up to five beds in each. Each ward had a conservatory and garden area that was well used in summer. On the day of the visit, Ward 37's conservatory was not accessible as the radiator in the room was broken.

In Ward 37, there was a separate dining and sitting area with a small activity room that on occasion was also used for storage of supplies. While both sitting and dining rooms were large and bright, there was little that provided stimulation in the environment.

In the sitting room, the furniture was very institutionalised and arranged in rows facing the television.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

Ward 39 had a combined dining and sitting area. This was bright and spacious, however as the area could also be used for activity provision and visiting, it could be busy and noisy. There was a small quiet room which was also used for interviews with patients and for relaxation sessions. This meant there was little opportunity for people on the ward to find a quiet space away from their peers.

There was still no therapeutic kitchen on site. This limits the occupational therapist's ability to undertake assessments and 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.

The Commission has made recommendations in relation to the poor physical environment of Wards 37 and 39 over a number of years and remains of the view that, despite some improvements, the wards are unfit for purpose. We are aware that the older adults mental health service review included a review of the inpatient provision, and this will shortly be publishing a range of options for consultation.  We look forward to the outcome of this.

## Summary of recommendations

There were no recommendations for Ward 39 on this visit.

**Recommendation 1:**
For Ward 37, managers should put a system in place to ensure that the most recent version of the care plan is readily identified.

**Recommendation 2:**
For Ward 37, managers should ensure nursing care plans are person-centred and reflect the current care needs of each person, setting out clearly the interventions and support required for the individual.

**Recommendation 3:**
For Ward 37, managers should ensure that risk assessments are reviewed on a regular basis.

**Recommendation 4:**
For Ward 37, managers should regularly audit the Getting to Know Me documentation to ensure this is fully completed and life history information is recorded and follows the patient when they move to a further care placement.

**Recommendation 5:**
For Ward 37, managers should ensure that where a proxy decision maker has powers to consent to medical treatment this person must be consulted and this process 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 an individual's care, treatment, and support are 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