Mental Welfare Commission for Scotland

Report on announced visit to: Wards 19 and 20, University Hospital Hairmyres, Eaglesham Road, Glasgow G75 8RG

Date of visit: 11 September 2019

Where we visited

Wards 19 and 20 are adult acute psychiatric admission units based in the grounds of Hairmyres District General Hospital. Both wards have similar clinical ward layouts with 25 beds in each plus one surge bed in each ward. The wards receive patients from across NHS Lanarkshire. On the day of our visit both wards were full.

The wards have multidisciplinary teams (MDT) consisting of psychiatry, psychology, nurses, occupational therapy and a peer support worker. There is regular access to pharmacy, dietetics and wider professions on referral. Social work are accessible as are advocacy services.

We last visited this service on 19 July 2018. We made recommendations around care plan improvements.

On the day of this visit we wanted to follow up on the previous concerns and ask patients how they viewed being a patient in this service.

Who we met with

We met with and/or reviewed the care and treatment of 13 patients and one relatives.

We spoke with one senior charge nurse, two charge nurses and a clinical psychologist and other staff nurses.

Commission visitors

Margo Fyfe, Nursing Officer

Mary Hattie, Nursing Officer

Mary Leroy, Nursing Officer

Paul Noyes, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

As at the time of our last visit we found the electronic record system, Midis, slow. We heard from staff that this system is cumbersome as it often goes down and takes a long time to log on to. This often leads to notes having to be handwritten and held in a paper file. Nurses continue to be frustrated at the time spent trying to update care files rather than on patient care needs. We are aware that the system is to be changed and look forward to seeing a more efficient system on future visits.

We were pleased to find that on looking through case files we found risk assessments to be regularly reviewed and one-to-one patient interactions to be well recorded. We found progress noted informative and easy to navigate. It was good to see that where discharge plans were in place these were being discussed with patients.

We were pleased to see that care plans are person-centred and in general are reviewed regularly. This had been highlighted in previous visits and we were pleased to see some improvement.

As at the time of our last visit, we found inconsistency in how the reviews are recorded with a lack of detail in some cases. We recommended an audit of care plan reviews to ensure consistency and clarity around content, actions, and progress. We repeat our previous recommendation and ask that this is addressed as soon as possible.

The commission has recently developed good practice guidance in relation to person centred care planning and this can be found at Person-Centred Care Plan Good Practice Guide

Recommendation 1:

Managers should ensure care plan reviews are audited to ensure constancy and clarity around content, actions and progress.

Multidisciplinary input to wards

During previous visits we have commented on the amount of consultant psychiatrists on each ward. On this occasion we heard that the number can vary from six to nine, or more, dependent on where patients have been admitted from. We understand the need to ensure each patient gets to see their consultant but wonder if this can be managed in another way so that less nursing time is taken up with medical meetings. We urge managers and medical staff to consider alternative ways of managing the situation.

At the time of our last visit we were informed of psychology having planned input to the wards. It was good to hear that this has continued in each ward. We had the opportunity to meet with the psychologist attached to the wards, who informed us that she sees patients as well as offering support to nursing staff carrying out direct patient interventions. She also carries out assessments and will make onward referrals to her community team colleagues when a patient is discharged. She informed us of hopes to introduce more structured group work on the wards as more staff are available to join her in this work. We look forward to hearing how this has progressed at future visits.

We were pleased to see that there is one peer support worker available to the patients in both wards and that funding has been identified to have another peer support worker in place which will allow 20 hours of peer support to each ward.

There is occupational therapy available in both wards. We heard that they offer one-to-one assessments and some group sessions as well as home assessments pre-discharge. We saw relevant notes to evidence this in patient files.

Use of mental health and incapacity legislation

We found legal documentation for detained patients in place and up to date. We also found consent to treatment documentation to be up to date and appropriate.

Rights and restrictions

As at our last visit we found reviews for any patients on an enhanced level of observation to be up to date along with relevant risk assessments. Patients met with said they felt involved in their care decisions and planning and knew how to contact advocacy should they wish to.

We heard about ongoing discussions around locking the ward doors. They are currently locked late evening and overnight. We aware the issue is to be further discussed at the Clinical Governance Group and that there is work ongoing around gathering patients views and how information can be fully distributed to patients. However the wards are quite isolated and having the doors locked for general safety, ensuring all patients can still come and go easily and are given clear information about the situation, does not seem unreasonable. We discussed the need to ensure clear policies and protocol are in place should the decision be taken to move this situation forward. We look forward to hearing about progress in this area.

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-mind/

Activity and occupation

When we last visited we noted that there was no activity programme on the wards but the occupational therapy staff offered some group activity such us cooking groups. We were informed that funding had been confirmed for the employment of two activity co-ordinators and that these posts would be advertised. Unfortunately we found that this had not happened and that nothing had changed in the provision of activity for patients. Patients met with told us they were often bored.

Recommendation 2:
Managers should progress the provision of activity co-ordinators to both wards.

The physical environment

The wards are designed like the other general health wards in the hospital. There is a clinical feel to the wards with little in the way of home comforts. However we did see some refurbishment that has meant new doors being fitted and shower rooms refitted in one of the

wards. We are aware the same work will be carried out in the other ward and look forward to seeing this during our next visit.

We were pleased to see that a room near the entrance to the ward, the Sanctuary, has been developed to provide a peaceful space off the ward for patient and relative use. During our last visit we heard that the family room on the same floor is being refurbished for patient and relative use. Unfortunately this has not yet happened but the charge nurses informed us of plans to take this forward soon. We look forward to hearing how these spaces have improved family visits in future.

Any other comments

Delayed discharges

We heard that there are around six patients whose discharge is delayed across the wards. However social work are engaged, and the senior charge nurses meet with the delayed discharge co-ordinator monthly to update on progress. We heard that links with community teams have improved and that discharge planning is inclusive of all disciplines involved in providing patient care.

We heard that there can be some issues in staff from community teams attending MDT meetings due to workload and distance. We are aware that some community teams are using video links into these meetings and would urge managers to consider this technology for wider use.

Summary of recommendations

1. Managers should ensure care plan reviews are urgently audited to ensure constancy and clarity around content, actions and progress.
2. Managers should progress the provision of activity co-ordinators to both wards.

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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