Mental Welfare Commission for Scotland

Report on announced visit to: Ward 3, University Hospital Wishaw General, 50 Netherton Street, Wishaw, ML2 0DP

Date of visit: 20 August 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face-to-face visits; however, this local visit was able to be carried out face-to-face.

Ward 3 is a mixed-sex, acute care and assessment ward for people over 65 with functional mental illness. The ward is situated in the University Hospital Wishaw General (UHWG). We last visited this service on 4 February 2021 when the ward had moved to the Udston Hospital site due to staff shortages during the pandemic. This was a virtual visit, and we made a recommendation about access to telephones for family contact; this was due to restrictions that were in place on visiting hospitals during the pandemic.

On the day of this visit we wanted to follow up on the previous recommendation and also hear about the impact on the recent move. Due to the Covid-19 pandemic, we were informed that Ward 3 (UHWG) was amalgamated with Clyde Ward in Udston Hospital. This plan was initiated to ensure appropriate staffing and service provisions for the patients. This allowed the Ward 3 space at (UHWG) to be prepared to be used as a ward for Covid-19 patients, should this need arise. Following the easing of restrictions Ward 3 have now returned to the (UHWG) site.

Who we met with

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

We spoke with the service manager, senior charge nurse and other clinical staff. We spoke to one carer by telephone.

Commission visitors

Mary Leroy, Nursing Officer

Lesley Patterson, Nursing Officer

What people told us and what we found?

Care, treatment, support and participation

On the day of the visit patients we spoke with were positive about their care and treatment, interactions between patients were warm and the staff were knowledgeable about the patients in their care.

Care planning

On a previous visit we made a recommendation regarding the need for improvement to nursing care plans. We reviewed individual patient files on the electronic system. We were pleased to see that care plans were detailed and person-centred with good information about specific interventions to meet the identified needs. There was clear identification of needs agreed goals and interventions. There was evidence of patient involvement in the care planning process, discussions that incorporated the patient's views. Of note we did see that the team had been focussing on improvement to the reviewing of the nursing care plans, the review process was detailed and linked well with individual goals and interventions within the care plans. This information and the identified actions from the multidisciplinary team (MDT) meeting ensured a clear narrative of the patient care journey.

Risk assessments were detailed, regularly reviewed and updated.

Multidisciplinary Team

The documentation of the MDT meeting is detailed and provides a good record. The MDT meetings are held on a weekly basis. The ward is served by six consultant psychiatrists, and meetings are held a Monday, Tuesday and Wednesday. The clinical decisions that occur during those meetings are clearly documented and generate an action plan with outcomes and treatment goals. Those weekly meetings were attended by medical and nursing staff and other members of the allied health care team. The MDT meetings also evidence patient involvement and attendance, some patients we met with spoke about their involvement in the decision making process.

Use of mental health and incapacity legislation

Within the ward some of the patients were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Most treatment provided under Part 16 of the Mental Health Act was authorised by either a T2/T3 certificate; however there were two omissions. These issues were highlighted to managers at the end of the visit.

Recommendation 1:

Managers should audit consent to treatment documentation to ensure that treatment is legally authorised.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

On review of the DNACPR (do not attempt cardiopulmonary resuscitation) order, one of the forms we reviewed displayed a lack of clarity about the review date.

The Scottish Government produced a revised policy on DNACPR in 2016: http//www.gov.scot/resource/0050/00504976.pdf. This makes it clear that, where an adult cannot consent and has an adult or guardian or welfare attorney with relevant powers, the guardian or attorney must participate in any advanced decisions to give or not to give CPR.

Where there is no guardian or attorney for a person who cannot consent to a decision about CPR , it is a requirement to consult with close family, as well as taking what steps where possible to establish the wishes of the patient. In all cases this involvement or consultation should be recorded.

It is fundamentally important that all relevant healthcare staff involved in the patients care are aware a decisions not to give CPR has been made and documented on the DNACPR form. This not only ensures that CPR treatment is not erroneously withheld, but also that inappropriate contraindicated and unwanted attempts at CPR which are of no benefit to the patient and can cause significant distress to patients and families is not attempted.

Recommendation 2:

Managers should carry out an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPOR status of every patient on the ward.

Rights and restrictions

Patients did comment that, although restrictions to visiting due to the pandemic were challengeable, and meant opportunities to visit friends and relatives in hospital were significantly reduced, the view was that nursing and medical staff had made a huge effort to maintain contact, provide regular updates and organise visiting schedules to ensure both patients and families kept in touch.

There were good links with advocacy services, and feedback from staff and patients about advocacy provision was positive. Advocacy services are clearly committed to representing the patients' wishes at Tribunal hearings, and meetings with consultants. Patients we spoke to had a good understanding of their rights and legal status.

One of the patients we met with discussed their advanced statement and the safeguard this offered them. The advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like to, or would not like, if they become ill again in the future. Section 276c of the Mental Health Act states that support for advance statements should be published by NHS Boards.

The Mental Welfare Commission has produced advanced statement guidance which can be found at: https://www.mwcscot.org.uk/node/241

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/law-and-rights/rights-mind

Therapeutic activity and occupation

On the day of the visit we met with the activity nurse, who discussed with us the model that had been used in the development the service. We noted there was good evidence of activity provision within the ward. The patients are individually, assessed then an individual activity plan is devised based on their needs. The activities that the individuals participate in are varied, and well captured in documentation. Also on meeting with patients many spoke with enthusiasm on both the role of the activity nurse and also the variety of recreational, social and therapeutic activities that was available to them. We also heard about the joint work with psychology who were participating in Getting well, relaxation and mindfulness groups.

The physical environment

The physical environment is bright, clean and spacious. We understand the restrictions in place due to the ward being within a district general hospital. However, we were pleased to see the attention to pictures in public areas and some modern furnishing in lounge and dining areas.

The ward has its own garden/courtyard, this outdoor space is appreciated and we were informed by the staff team of the plans to improve this space through redesign and using raised beds for planting. We were also able to see the newly refurbished Activity room and a well-stocked activity cupboard.

Summary of recommendations

Recommendation 1:

Managers should audit consent to treatment documentation to ensure that treatment is legally authorised.

Recommendation 2:

Managers should carry out an audit of all DNACPR forms to ensure that, where relevant, all DNACPR decisions are reviewed and consider implementing a system to ensure that all staff members are aware of the DNACPOR status of every patient on the ward.

Good practice

We discussed the Lanarkshire Quality Approach and the staff spoke to us about a recent development the 'Quality Improvement Board'. The ward has been identified to pilot this project, and they described the main headings within the project: promoting a culture of safety, care assurance and accreditation system (CAAS standards), infection protection and control, working in partnership with patients, improving quality and working in partnership with carers.

They have just commenced with early stages data collection, updated onto the Quality and Safety Information Board. The Board allows a quick over view of all the areas the team are developing and progressing on. The Board is in the ward corridor for staff, patients and visitors to view.

We look forwarding to hearing about the progression of this initiative and its impact on the improvement of patient care.

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.

ALISON THOMSON
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 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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