Mental Welfare Commission for Scotland

Report on announced visit to: Ward 19, University Hospital Hairmyres, 218 Eaglesham Road, East Kilbride, Glasgow, G75 8RG.

Date of visit: 20 January 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods during the pandemic where we have been unable to conduct our face-to-face visits; however, this local visit was carried out face-to-face.

Ward 19 is an adult psychiatric admission unit, based in the grounds of University Hospital Hairmyres. The ward has 25 beds and receive patients from across Lanarkshire. At the time of our visit there were 20 patients in the ward, eight of whom were subject to the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act').

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

We last visited this service on the 11 September 2019. On the day of the visit we wanted to follow up on previous recommendations regarding nursing care plans, both content and reviewing process, and the lack of activities within the ward.

Who we met with

We met with and/or reviewed the care and treatment of six patients. Unfortunately no carers/relatives/friends were available to speak with us on this occasion.

We spoke to the nurse in charge on the day and the service manager, In addition we also met with one of the consultant psychiatrists from the service.

Commission visitors

Mary Leroy, Nursing Officer

Justin McNicholl, Social Work Officer

What people told us and what we found?

Impact of the pandemic

Ward 19 had a period of isolation due to a recent Covid-19 infection. The senior charge nurse (SCN) informed us, that the weeks prior to Christmas had been challenging for the service, this related to the surge and increase in infections due to the new Omicron variant. This impacted on staffing, due to rules around self-isolating, and awaiting test results, and increase in rate of transmission and infection, this led to high levels of staff absences.

The senior manager informed us that the service managed with a combination of regular ward staff working extra shifts and commissioned agency staff to assist during this period of time.

Electronic records

We were told that that Ward 19 has now migrated to the new electronic recording system "Morse". The staff informed us that the new electronic system is faster and more intuitive to navigate than the previous system. They described the "roll out" of the new system as smooth and that the involvement of clinicians in both design and rollout had ensured that this had gone well for the service.

The team described some early challenges, however told us that they are well supported by the Morse IT team.

We heard from the charge nurse and other members of the clinical team state that thy find the new system easier and a better system to use for care planning and evidencing patient involvement. The staff have uploaded care plan documentation, risk assessments, chronological notes and MDT meeting documentation.

Care and treatment, support and participation

Feedback from the patients was generally favourable about their stay in hospital. Most patients told us they felt safe in the ward environment, and spoke positively about the clinical team who supported them. We saw interactions between staff and patients which were warm and supportive. In speaking to staff it was evident they knew the patients well.

We reviewed the patients' electronic files; there was easy access to risk assessments which were robust and regularly reviewed.

All the nursing care plans we reviewed were person centred and an accurate reflection of the care delivered. They were dynamic with good links to the outcomes from the multidisciplinary team meetings. We also noted good attention to physical health care plans.

During our last visit to Ward 19, we made a recommendation around nursing care plan reviews. On this visit we were pleased to hear about the care plan auditing process. In the individual files we looked at, we saw that reviews were thoughtful and meaningful, and detailed progress and changes in patient care. We also noted that the new electronic system has a clear section that evidence patient involvement, specifically their views of their care plans.

We also saw good evidence of engagement with families and patients in the daily progress notes.

Multidisciplinary Team

We found the documentation for MDT meetings is detailed and provides a good record. The MDT meetings are held weekly. The clinical decisions that occur during those meetings are clearly documented and generate an action plan with outcomes and treatment goals. In attendance at the MDT meeting there is medical staff, nursing staff, occupational therapist and psychology input. We were also told that both patients and families are invited to attend the meeting.

We heard that occupational therapy is available on the ward, offering one to one assessments and some group sessions, as well as home assessment pre-discharge. We saw relevant notes to evidence this in the patient's electronic files.

We were informed that there were four patients whose discharge was delayed. However we did note social work were engaged, and the senior charge nurse meets with the delayed discharge coordinator monthly to update on progress.

Use of mental health and incapacity legislation

The patients we met with during the visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act. Where patients in the ward were detained under the Mental Health Act there were copies of the detention paperwork were on file.

Part 16 (s235-248) 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. Certificates authorising treatment (T2/3) under the Mental Health Act were in place where required and authorised all treatment prescribed.

Where individuals lacked capacity to make decisions about their health care, Section 47 (s47) certificates, which authorise treatment under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), were in place.

We discussed s47 certification with the SCN on the day of the visit. We also noted that copies of s47 certificates were generally kept in the individual patient's paper-lite files, and were not stored with the individual patient's medication chart. We suggested a copy of this certificate should be kept with the medication chart so that it is clear to anyone administering medication what specific treatment is authorised by the s47 certificate.

Rights and restrictions

We were told that advocacy input is available on request and that the patients who use this find it valuable and supportive.

A significant issue across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. During lockdown the ward has utilised technology to ensure links with key people were maintained. We heard that technology as a means of communicating has been a positive addition to the range of ways patients can maintain contact with important individuals in their lives. We were pleased to hear that face to face visiting has resumed in line with guidance from Scottish Government.

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

Activity and occupation

We did note involvement of the occupational therapist, who offered cooking assessment and skills development for some patients.

We were pleased to hear that a peer support worker is available on the ward. We were informed that they can provide support on a one-to-one basis and in a group, as required.

We also heard from patients who described "it was a long day on the ward" with little activity, which led to feelings of boredom.

We were informed on our last visit that there were plans to employ an activity coordinator. Unfortunately this has not been progressed. Research indicates that greater staff patient interaction and specifically greater patient activity, both therapeutic and recreational, improves clinical outcomes for patients with mental illness. We therefore repeat the recommendation.

Recommendation 1:

Managers should progress the provision of activity co-coordinators in the ward. We would like to see progression of the activity coordinator role prioritised.

The physical environment

The ward is designed like other general health wards in hospital. The ward has a clinical feel and there is little in the way of home comforts. We have raised this concern about the admission wards for mental health patients with NHS Lanarkshire managers over the years but understand that infection control rules in the hospitals will not allow for any exceptions in ward functions in order to create more homely environments. We would hope that managers will continue to have discussions to find ways to make the wards feel less clinical and look forward to seeing changes at future visits. We discussed the ongoing renovation refurbishment schedule and saw that new doors have been fitted and refurbishment of bathroom areas in the dorms. The ward has access to a small enclosed garden area, we were told that the service is planning to buy new garden furniture.

Any other comments

The service manager discussed with us the increase in referral and admission rates of CAMHS patients into the service. The service manager further acknowledged that moving young patients on to a more appropriate service happens quickly when a bed is available. The service also commented on the positive links with Skye House for advice, guidance and support if required for the young person.

We discussed the impact of having enhanced observation and intervention, the staff skill mix, and respective appropriate and required training for staff.

The service are reviewing and analysing statistics regarding this matter, to allow better planning for the future. We look forward to hearing about this review on our next visit to the service.

Summary of recommendations

1. Managers should progress the provision of activity co-coordinators in the wards. We would like to see progression of the activity coordinator role prioritised.

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.

Suzanne McGuinness
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 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 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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