Mental Welfare Commission for Scotland

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

Date of visit: 10 June 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 where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Ward 20 is a 26-bedded adult acute psychiatric admission unit based in the grounds of University Hospital Hairmyres. The ward receives patients from across NHS Lanarkshire, but primarily from East Kilbride, Strathaven and Clydesdale areas. On the day of our visit the ward had one empty bed.

We last visited this service on 11 September 2019 and made recommendations around the quality of care plans and the provision of an activity coordinator for the ward.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how patients and staff have managed throughout the current Covid-19 pandemic.

Who we met with

We met with and reviewed the care and treatment of five patients. No relatives requested a meeting with us.
We also spoke with the clinical service manager, a senior charge nurse and a staff nurse.

Commission visitors

Lesley Paterson, senior manager (practitioners)
Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support and participation

Throughout the visit we saw kind and caring interactions between staff and patients. The patients we spoke to told us they were well looked after and most felt valued, listened to and that most staff genuinely cared for them. Some patients did mention that sometimes they hear staff talking about other patients whilst sitting at the nurse's station. This was conveyed to senior managers on the day.

Care records

At the time of our last visit, the service was using MIDAS for electronic recording, however we heard from staff that it was slow and cumbersome. We were pleased to hear that the service has moved to using 'Morse' for electronic recording and staff report it is a much more efficient, user friendly and intuitive system. In each patient record, there was evidence of robust risk assessment and risk management which detailed historical factors, current issues and prescribed interventions. These were regularly reviewed. One-to-one patient and staff interactions were frequent and recorded in detail and daily continuation notes were thorough and informative.

Nursing care plans

The quality of the care plans was variable. Some were detailed and person-centred, whilst others lacked detail, with no clear identified needs; others were incomplete. We also saw care plans where the content had been copied and pasted from another patients care plan. While there was evidence of regular care plan reviews, many of these reviews lacked detail, were repetitive and did not evidence an accurate review of the effectiveness of interventions. We were told that care plans were audited, however we would suggest this process is reviewed, as it does not appear to be resulting in high quality, individualised care plans.

On a positive note, we did see some evidence of patient involvement in the care planning process. Following our last two visits to the ward we have made recommendations about the quality of care plans and the need for an effective audit tool. We repeat our previous recommendations and ask that this is addressed as soon as possible.

The Commission has published a good practice guide on care plans. 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, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:

Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, identify clear interventions and care goals and reviews are meaningful.

Recommendation 2:

Managers should introduce a robust audit tool and undertake regular audits of care plans to ensure consistency in the quality of recording and review.

Multidisciplinary team (MDT)

The ward has a multidisciplinary team (MDT) consisting of nursing, psychiatry, psychology, and occupational therapy. There is regular access to pharmacy, dietetics and other allied health professions on referral. Social work and advocacy are also accessible. During previous visits we had commented on the amount of consultant psychiatrists aligned to the ward and how this could impact on all other members of the MDT who are required to attend each of these MDT meetings. We heard that there are still five inpatient consultant psychiatrists, who also have community responsibilities; however staff told us that this was manageable and did not impact negatively on their time. Each consultant held a weekly MDT meeting on the ward, which was attended by nursing, medical, psychology, occupational therapy (OT), social work and pharmacy staff. Patients and their relatives / carers could also attend if they wished, and we saw evidence of this. The MDT meeting records were well presented, they recorded who attended each meeting, contained a concise summary and recorded outcomes and actions.

The ward continues to benefit from psychology input. The psychologist delivers psychological group work and individual sessions, carries out cognitive assessments and facilitates complex case discussions with staff. The psychologist makes onward referrals to their community team colleagues, as appropriate, when a patient is discharged.

Use of mental health and incapacity legislation

On the day of our visit, 11 patients were detained under the Mental Health (Care & Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Mental Health Act paperwork for all detained patients was stored in a separate folder, it was in order and easy to access.

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. We found that the legal documentation used by the responsible medical officer to record consent (T2) or non-consent (T3) to treatment were not completed for all patients who required them and those that were available did not always correspond with the medication that had been prescribed. We discussed these issues on the day and will follow up with the manager for the service. We also found that in some cases, there had been delays in the completion of these forms, which meant that for those patients, psychotropic medication had been given for a number of weeks without the required legal authority. We have asked that the patients affected by these discrepancies are made aware of this, are able to access advocacy and are supported to seek legal advice if they wish.

Recommendation 3:

Managers must ensure that all psychotropic medication is legally authorised on either a T2 or T3 form and a system of regularly auditing for compliance with this should be put in place.

There was one patient subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act 2000 (AWIA) and another for whom the local authority were in the process of submitting an application. Where patients are subject to guardianship orders, a copy of the powers granted should be held in the patients file. We could see no evidence of the powers in the patient file and there seemed to be confusion and ambiguity among some of the staff regarding AWIA status, orders, powers and how aspects of care and treatment are managed if a patient happens to be subject to both the AWIA and Mental Health Act.

Recommendation 4:

Managers should consider appropriate staff training to ensure all staff working in the ward have a clear understanding of the Adults with Incapacity (Scotland) Act 2000.

Recommendation 5:

Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are contained within the patients file.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. No patients in Ward 20 had an advanced statement. When we discussed this with nursing staff, we heard that the MDT recording tool was being revised to have a prompt for staff to ask patients about advanced statements. Whilst this was positive, it was apparent that advanced statements are not promoted in the ward. The Mental Welfare Commission has produced advanced statement guidance which can be found at:
https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidance.pdf

Recommendation 6:

Managers should ensure that advanced statements are promoted within the ward and these discussions are recorded and regularly reviewed in the patient records.

Rights and restrictions

The patients we met with said they felt involved in decisions about their care and treatment and knew how to contact advocacy, should they wish to. Staff told us that input from advocacy services is good and there is a decent uptake across the ward.

Entry in and out of Ward 20 is via a keypad entry system. This meant visitors and the general public cannot freely access the ward. This decision was made to limit free access during the recent Covid-19 pandemic and this ensures the ward (which is quite isolated) is secure. Although the door is locked, patients and their visitors can leave easily as the code for the keypad entry is next to the door, inside the ward. There is a locked door policy, which all patients and relatives have access to. All of the patients that we spoke to, who were detained under the Mental Health Act, appeared to be aware of their rights.

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 occupational therapy (OT) service was based in the hospital and we were told that the ward benefitted from good OT provision. There is also a peer support worker available to the patients. OT staff meet with patients early in their admission to identify their interests and tailor an activity plan for them. OT and nursing staff facilitate the group and individual

activities, with OT staff also carrying out functional assessments and pre-discharge home assessments, when required. Activities that are on offer included cooking sessions, quizzes, walking groups, gardening and arts and crafts. Whilst we saw evidence of participation in these activities in patient files, some patients still felt there was little to do. Patients told us they missed the yoga, relaxation and reiki which were previously on offer. Staff told us that these activities had stopped due to the Covid-19 pandemic, however it is hoped that these will recommence soon. For a number of years there have been ongoing plans to introduce patient activity coordinator posts. We were told that these plans have now progressed and will hopefully be advertised soon. We look forward to seeing how this progresses when we next visit.

The physical environment

The wards are designed like the other general health wards in the hospital, with a clinical feel and little in the way of home comforts. Refurbishment work does however continue, with the ward looking better than it was on our last visit. We look forward to seeing these continued improvements during our next visit.

We were pleased to see that a room near the entrance to the ward, the Sanctuary, continued to be well used by patients, and their relatives, as a peaceful and calm space off the ward. Two patients told us of their concern that the television in the day area was not securely attached to the wall and commented that this was dangerous. We passed these concerns to staff on the day and were assured this matter would be dealt with immediately. The ward has a mixture of single rooms and dormitories; as there are only four single rooms, most of the patient sleep in dormitories and some patients did raise the lack of privacy as a problem.

The garden area is to the rear of the ward and was looking tired, overgrown and in need of work. We were pleased to hear that funding to restore this has been secured and this work will soon begin. We look forward to seeing the results on our next visit.

Any other comments

Although the Covid-19 situation has been a devastating and traumatic time, it has presented challenges that have required collaboration, commitment and creativity to find new ways of working. We were impressed with the way in which this service has adapted and we look forward to seeing the continued progress as services emerge from the pandemic.

Summary of recommendations

1. Managers should ensure nursing care plans are person-centred, contain individualised information, reflect the care needs of each person, identify clear interventions and care goals and reviews are meaningful.

2. Managers should introduce a robust audit tool and undertake regular audits of care plans to ensure consistency in the quality of recording and review.

3. Managers must ensure that all psychotropic medication is legally authorised on either a T2 or T3 form and a system of regularly auditing compliance with this should be put in place.

4. Managers should consider appropriate staff training to ensure all staff working in the ward have a working understanding of the Adults with Incapacity (Scotland) Act 2000.

5. Managers should undertake an audit to ensure that where there is a proxy decision maker, a copy of the powers granted are contained in the patients file.

6. Managers should ensure that advanced statements are promoted in the ward and these discussions are recorded and regularly reviewed within the patient records.

Good practice

We heard about monthly 'planned date of discharge' meetings which had recently began. These patient centred, multidisciplinary meetings focus on looking at discharge differently and ensuring patients are kept at the centre of all discharge planning. We were pleased to hear that this new way of working had positively impacted delayed discharges and we look forward to seeing the further analysis of this.

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.

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 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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