Mental Welfare Commission for Scotland

Report on unannounced visit to:

Ward 19, Hairmyres Hospital, 218 Eaglesham Road, East Kilbride, Glasgow, G75 8RG

Date of visit: 4 May 2023

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 19 is a 25-bedded unit, divided into four dormitory areas and five en-suite side rooms, one side room has two beds, also with en-suite facilities. The unit provides assessment and treatment for adults who have a mental illness. On the day of our visit, there were four vacant beds.

We last visited this service on 20 January 2022 and made recommendations about the provision of activity co-coordinators in the wards. The response that we received from the service in relation to this was that the workforce and skill mix was being reviewed in order to develop an activity co-ordinator post across all adult mental health wards.

On the day of this visit we wanted to follow up on the previous recommendation and also to hear how patients and staff had managed throughout the recent pandemic and how the re-introduction of activities for the patients has impacted on the staff levels.

Who we met with

We met with, and reviewed the care of six patients, five who we met with in person and one who we reviewed the care notes of. We did not speak with any relatives due this being an unannounced visit, so no prior notice could be given.

We spoke with the senior charge nurse, the charge nurse and other members of the nursing team.

Commission visitors

Anne Craig, social work officer

Margo Fyfe, senior manager

What people told us and what we found

Care, treatment, support and participation

The patients we met with were complimentary of the nursing and medical teams. One patient said, "I love it here, the company is great"; another patient told us "staff are okay and they supported me well". We were also told, "it is never boring, the patients are so interesting."

Throughout the visit we observed positive, compassionate and beneficial interactions between staff and patients, and staff that we spoke with knew the patient group well. The ward was calm, influenced by charge nurse who clearly had the skills and knowledge required of a team leader. We commented on this to the senior charge nurse and the charge nurse during our visit.

However we also heard that staffing was, and still is a challenge. We heard that recently there had been some promoted posts that left staffing gaps, although these had been quickly filled by nursing staff who have previously been on placement as students on the ward. This is beneficial for the management team but also the patients, as the new staff would be able to support the ongoing running of the ward.

We heard that the ward had been locked down on a number of occasions, and during a recent outbreak of Covid-19, the staff were able to manage this using a "bubble" system to minimise infection. This also meant that infection control requirements were still being met, but patients were able to enjoy being outdoors or in small groups. The staff have worked hard, supported by infection control guidance, to successfully contain outbreaks.

Care plans

When we last visited the service, we found examples of detailed and person-centred care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. On this occasion, we again were pleased to find detailed person-centred care plans that evidenced patient involvement.

However, we were unable to locate robust reviews that targeted nursing intervention and individuals' progress. There was a clear awareness of reviews happening but not being reflected in the paperwork. We discussed this with the senior charge nurse and the charge nurse on the day of our visit and they were receptive to our comments. We suggested using the Commission guidance on our website to help in the process.

Discharge care plans were in place where appropriate and discharges were supported by an on-site discharge co-ordinator in order to reduce delays. We also found helpful information contained in patient's one-to-one discussions with their named nurse.

We saw that physical health care needs were being addressed and followed up appropriately.

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 carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Multidisciplinary team (MDT)

The unit has a broad range of disciplines either based there or accessible to them. There were a number of consultant psychiatrists who had patients on the ward and MDT meetings were held over a number of days in the week. We heard that there were a small number of patients who have learning disabilities on the ward as there was no availability for admissions to the dedicated learning disability hospital. We felt that it would be helpful if specialist learning disability support could have been provided to the staff on the ward when caring for this group of patients.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meetings and given an update on their views. This also included the patient and their families, should they wish to attend. There were good links between the MDT decisions that were then followed up the care plans. It was clear to see from these notes that when the patient was moving towards discharge that community services also attended the meetings. One patient commented that they "felt listened to most of the time and involved in care discussions".

We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. A hybrid model continued to be in place, with the majority of participants now attending face-to-face, although online attendance could also be facilitated as required.

Care records

Information on patients care and treatment was held in two ways. There was a paper file and an the electronic record; we found both easy to navigate. In the front of the paper files there was an index of where to find information, although there was often duplication of the paper files. On the electronic system, Morse, there were opportunities to quickly reference information rather than seeking an available computer to access, especially in times of urgently requiring information.

We saw robust risk assessments that were updated in a timely manner and were detailed. A few of the patients that were recently admitted had an initial 72-hour care plan in place. There were timely MDT meetings that provided the forum for more person-centred and detailed care plans to be created to support the patients' care during admission.

Use of mental health and incapacity legislation

On the day of our visit, 11 of the 21 patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Most of the patients we met with during our visit had a good understanding of their detained status where they were subject to detention under the Mental Health Act. There were three patients receiving constant observations.

All documentation pertaining to the Mental Health Act around capacity to consent to treatment was in place in the paper files, and was up-to-date.

Part 16 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed. We found that all T3s had been completed by the responsible medical officer to record non-consent; they were available and up-to-date.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

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 (AWI) 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. Patients subject to Adults with Incapacity legislation require to have an s47 certificate in place to authorise medical treatment although this does not cover treatment under the Mental Health Act. We noted one patient had a s47 certificate in place but it had been incorrectly completed in line with the legislation. We spoke with the charge nurse who immediately made arrangements to have the certificate completed by the patient's Responsible Medical Officer.

Recommendation 2:
Managers should ensure that where a patient is subject to Adults with Incapacity legislation that the section 47 certificate is completed appropriately.

Rights and restrictions

Ward 19 continued to operate a locked door, commensurate with the level of risk identified in the patient group; access was by buzzer entry from the outside.

Where specified person restrictions were in place under the Mental Health Act, we found reasoned opinions in place. As stated in our last report, sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit there was one specified person and all appropriate paperwork was in place and on file.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

When we are reviewing patient files, we looked for copies of advance statements. The term 'advance 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. On the day of our visit, we did not see any patients who had an advance statement

recorded. We spoke with the charge nurse who confirmed that they do try to encourage patients to complete an advance statement when they are well enough to do so.

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

During the pandemic, restrictions that were put in place meant that various activities out with the unit had to be paused. Our previous visit recommendation was to secure the services of an activity co-ordinator for the ward; unfortunately this has not yet progressed. We look forward to seeing how this is progressed when we next visit.

However, we heard about the efforts of nursing staff to ensure there was always activity available on the unit for patients. The ability of the nursing staff to support patient activity was dependent on the acuity of the patients on the ward and shift staffing levels.

Now that restrictions have eased, patients are once again able to resume time off ward activities. We heard that staff go the extra mile to facilitate activity and ensure patients' needs in this area are met.

The physical environment

The layout of the ward consisted of single rooms and shared dormitories. There was a lounge area and a separate dining area for the patients, as well as a quiet room. All were bright and spacious. The environment was acceptable, but we felt that further work to make the main areas more homely and welcoming would be beneficial. Some of the rooms had already been upgraded and unobtrusive observational screening on the internal windows had been completed. This will prevent the patients being disturbed whilst resting in their rooms.

The ward benefits from good outside space for patients to use. We felt that the area would have benefitted from some outdoor maintenance, and that this could encourage the patients to use this as a therapeutic area to enjoy. We heard how access to the garden from the ward really helped patients where fresh air was important for their wellbeing, and we consider that it is important for patients to have access to outdoor safe space.

Summary of recommendations

Recommendation 1:
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

Recommendation 2:
Managers should ensure that where a patient is subject to Adults with Incapacity legislation that the section 47 certificate is completed appropriately.

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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