Mental Welfare Commission for Scotland

Report on unannounced visit to:

Ward 2 Wishaw General University Hospital, Netherton Street, Wishaw, ML2 0DP

Date of visit: 15 February 2024

Where we visited

Ward 2 is a mixed-sex, adult acute mental health admission wards in Wishaw General University Hospital. The ward is situated in the lower ground floor with access to enclosed garden areas. The ward has 23 beds which were all occupied on the day of our visit. The ward covers Coatbridge, Airdrie and Cumbernauld areas of Lanarkshire, offering a service to adults between 18 and 65 years old.

Throughout the visit we observed positive, compassionate and therapeutic interactions between staff and patients, and staff we spoke with knew the patient group well. The atmosphere on the ward was calm and the positive leadership of the nursing leads in the ward was evident; we commented on this to the senior charge nurse and the charge nurse during our visit. We were pleased to hear that the ward had been fully staffed from the start of 2024.

We last visited this service in February 2022 and made a recommendation about the progress/re-establishing of the provision of activity co-ordinators in the wards. The response we received from the service was that workforce and skill-mix was being reviewed to develop a Band 3 activity co-ordinator post across all adult mental health wards.

Who we met with

We met with and or reviewed the care and treatment of six patients and spoke with one relative on the telephone.

We spoke with the service manager, the senior charge nurse, and the charge nurse. As this was an unannounced visit it was difficult for us to speak with members of the wider multidisciplinary team (MDT).

Commission visitors

Anne Craig, social work officer

Mary Leroy, nursing officer

What people told us and what we found

Care, treatment, support and participation

Without exception, everyone we spoke with who could offer a view had nothing but praise for the service, particularly noting the care and support received from the nursing staff and the consultant psychiatrists. One person told us of their consultant, "he's good to me, he never forgets my name and that makes me feel good". One person told us that "the nurses are good" and another said, "I feel really safe". We were also told the senior charge nurse was "good to their staff" and the charge nurse "keeps me going, they're lovely". There was also specific feedback for the support received from the occupational therapist (OT), who was able to provide not only OT input but had a knowledge of benefits, housing and community supports. One individual noted that the OT "is really good. We go for walks, also visit the gym and they help me with cooking from scratch".

We saw the peer support worker spending time with some of the people in the ward and heard comments that their input was valuable to individuals. One person said that "they have a good influence on the ward". The nursing team also commented on the peer support worker's positive influence on the ward in general and how well people respond to them.

Care plans and nursing notes

MORSE is an electronic recording system which is now well established in all mental health wards in NHS Lanarkshire. We found this easy to navigate although the system did seem a little unstable during our visit; we were later told that this was due to a recent upgrade, but we were easily able to access care plans, reviews, multidisciplinary (MDT) meeting notes and nursing notes. For ease of access, some patient information was in a paper file, the information was duplicated on MORSE and was for quick reference when required. Hospital ePrescribing and Medicines Administration (HEPMA) is also now well established in NHS Lanarkshire.

We could see from the records that care plans were detailed and person-centred. They focused on the physical and mental health of the individuals and had clear links to multidisciplinary team (MDT) decision making. There was also a summary of the decisions made at the MDT meetings in the nursing notes. There was a focus on the physical health of the patients on the ward and a few people had significant physical health conditions. We heard that the senior nursing team that they had used the Commission's good practice guide on care planning from the Commission's website, to support staff in creating meaningful and detailed care plans.

The care plans provided a good account of each individual's journey and recovery. We spoke with one relative prior to the visit and while they praised the care and support that their family member had received, they were concerned about the appropriateness of the ward setting. When we asked about this on behalf of the relative, we were assured that the local HSCP is undertaking an updated assessment to try to find a more suitable placement for the individual.

Risk assessments were robust and detailed; a traffic light system was being used, and we found it easy to see where risks were identified, with subsequent further explanation at the

end of each section. We also found detailed information contained in individuals' one-to-one discussions with their named nurse.

Multidisciplinary team (MDT)

The multidisciplinary team (MDT) input to the ward consisted of medical staff, nursing staff, psychology, occupational therapists (OTs) and peer support worker. Social work staff attend the ward meetings as required and advocacy services attend on a referral basis. Pharmacy also offers regular input. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and give an update on their views. This also included the views of individuals and their families, should they wish to attend. There were notable links between the MDT decisions that were then followed through in the care plans.

In Ward 2, there were a few individuals 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. The service manager highlighted that the service benefitted from a model that operates a planned day of discharge, therefore discharge planning commences at point of admission; this is deemed good practice.

Use of mental health and incapacity legislation

On the day of our visit 12 of the 23 people on the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003. There was one person boarding from another ward. Most of the individuals we met with during our visit, where they could, had a good understanding of their detained status when they were subject to detention under the Mental Health Act. There were three people receiving enhanced observations.

On reviewing all of the documentation, we found that all paperwork was in order. One person was detained on a compulsory treatment order and had a welfare guardianship in place. We briefly discussed this at the end of the visit and the visit co-ordinator agreed to review this patient again to see if the compulsory treatment order should be revoked. There were no specified persons on the ward on the day of the visit.

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

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, 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 for staff access and up-to-date.

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. Individuals subject to Adults

With Incapacity legislation require to have a section 47 certificate in place to authorise medical treatment, although this does not cover treatment under the Mental Health Act. There were two people who had s47 certificates in place.

We discussed the use of advance statements and named persons notifications. The staff take an individual approach when discussing these, finding a time when the patient would be able to make a decision about this.

Rights and restrictions

Ward 2, University Hospital Wishaw General operates a locked door policy, commensurate with the level of risk identified with the patient group. Access was by buzzer entry from the outside and individuals can leave the ward using the exit button at the inner door, when this has been agreed by the responsible medical officer and MDT. The activity at this door was constantly monitored by the nursing team.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that individuals 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

On our previous visit, we recommended that managers should progress/re-establish the provision of activity co-ordinators in the ward. An action plan from the service manager in July 2022 confirmed that the workforce and skill mix was being reviewed to create dedicated Band 3 posts to undertake the role of activity co-ordinators. We heard that at this time, the ward still does not have a member of the team who undertakes this role. Ward staff have been approached about who would like to be considered, what they feel they could bring to the role and how they could make it work for the patient group. This remains an ongoing recommendation and the senior staff team are keen to take this forward. This role will complement the existing role undertaken by the peer support worker and the occupational therapist. We noted that the activities board in the ward only had activities on four days, Monday to Thursday. We were told that staff try, as far as possible, to provide meaningful activity out with these times.

The staff are hoping to engage with one of the local colleges who would attend the ward on a regular basis to provide some sessions to people on topics such as health, wellbeing and beauty.

Recommendation 1:
Managers should ensure progress is made to establish/re-establish the provision of activity co-ordinators in the ward.

The physical environment

The environment was clean and bright, and we were able to see where efforts had been made to soften corridors and public rooms with artwork and photographs on the walls. The layout of the ward consists of 11 single en-suite rooms with showers and three multi-occupancy rooms with four beds in each. There was a separate bathroom area that could accommodate

patients who had physical disabilities requiring more specialist equipment. However, staff told us that this room is not used in this way and is now a storage room for various items of equipment and some personal belongings as they have no other storage facilities.

As storage space is a significant problem in Ward 2, there has been a request to remove the assisted bath and have this area redesigned in a way that would allow for effective and efficient storage. This upgrading work has been agreed, but timeframes for this are not yet confirmed. We look forward to seeing the completion of this work on our next visit.

There was a communal lounge area which we noted was in constant use, and a quiet room for individuals to enjoy with low lighting, soft seating (beanbags) and a bubble/light tube. There was also a projector that could be used in this room which projects shapes and pictures onto the ceiling. The dining area was large, bright, and welcoming.

We were pleased to see a display of leaflets available on various aspects of mental disorders and what to expect. We were told this was well used and one of person commented on how helpful these had been to them.

The ward benefits from outside space for people to use, however, it was quite overgrown and not particularly inviting. We felt that the area would have benefitted from some outdoor maintenance, and we heard that finance has been identified to make changes to this area, which should encourage the people to use this as a therapeutic space. Access to the garden from the ward was through the quiet room which was not ideal, but other alternatives that could provide access were not available. We consider that it is important for people to have access to outdoor space, as fresh air is important for wellbeing, particularly for those who are not able to leave the ward to go to any other areas of the hospital.

Any other comments

We noticed a poster on the wall as we entered the ward that advertised a laundry service for patients which had a cost (to the individual) attached. We asked about this service and the team explained that there are no laundry facilities available for people who do not have families able to do this for them. A local service will pick up a person's laundry and bring it back to them, at a cost. The senior staff team have raised this with the hospital managers as they are also concerned about this. This is a particular concern where an individual is detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 and unable to leave the ward and have no family to attend to their laundry. To have clean clothes they must use this service at a personal cost. We feel this puts some patients at financial detriment, mostly those who are compulsory detained. This should not be the case.

Recommendation 2:
Managers should review the situation with laundry provision in Ward 2 so that there is no financial detriment to any individuals.

Summary of recommendations

Recommendation 1:
Managers should ensure progress is made to establish/re-establish the provision of activity co-ordinators in the ward.

Recommendation 2:
Managers should review the situation with laundry provision in Ward 2 so that there is no financial detriment to any individuals.

Service response to recommendations.

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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