Mental Welfare Commission for Scotland

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

Date of visit: 10 April 2024

Where we visited

Ward 3 is an older adult admission and assessment ward for people with various mental illnesses, excluding dementia. It is a 23-bedded, mixed-sex unit in the mental health department of University Hospital Wishaw. The ward accepts individuals from areas including Motherwell, Bellshill, Coatbridge, Airdrie, and Clydesdale.

On the day of our visit, there were 16 people on the ward.

We last visited this service in August 2021on an announced visit.

On the day of this visit, we wanted to follow up on the previous recommendations about treatment being legally authorised and increasing staff awareness about DNACPR patients' status.

Who we met with

We met with, and reviewed the care of six people, five who we met with in person and one who we reviewed the care notes of. We also spoke with two relatives by telephone.

We spoke with the service manager, the senior charge nurse, the charge nurse, and the activity co-ordinator.

Commission visitors

Anne Craig, social work officer

Margo Fyfe, senior manager

What people told us and what we found

On the day of our visit everyone we spoke with was positive about their care and treatment. We witnessed warm and interactive interventions by the nursing team with the people on the ward. One person said that the nurses were “outstanding” and “a beautiful group of people” and that “nothing was a bother”. Another person said that staff were “brilliant” and that “they were all so good natured”. They also said, “nurses are all good, 100% in everything they do”, also adding that “they were very well cared for” and “it feels like a big family”.

Many of the people we spoke with were able to leave the ward either with family or, when possible, staff escorted them to the garden area or around the grounds of the hospital. Comments on the food varied; some people told us it was very good, but others told us it was either over or undercooked. We heard “the food isn’t good”.

When speaking with families and carers, again there were positive comments for the staff team. We heard that they “couldn’t thank the staff enough”, that “communication is excellent”, “staff are amazing”, “care delivery is 100%”, “I know my loved one will be looked after if I can’t visit” and “they take on board what I say too”. A family told us that they “couldn’t fault the team and the consultant is outstanding” and “nurses have been great”. This relative cited the night staff at Easter putting out an Easter egg for every person on the ward to wake up to. We were also told “they have all been amazing with my loved one”.

During our visit, we found the ward to be calm and welcoming. We saw staff who were engaging fully, clearly enjoying this, and the patients who in turn, were responsive and benefiting from the interaction. It was clear that staff enjoyed working on the ward; we noted that some staff have been in the ward for a number of years and their work was giving them a great deal of job satisfaction.

Care, treatment, support and participation

Care records

Information on each individual’s care and treatment was stored in two ways; MORSE, the electronic record system and a paper light file that contained legal paperwork such as Mental Health Act records for the person and other information for quick reference, such as contact details and information on the GP, community psychiatric nurse and so on. All the information contained in the paper files was available on MORSE. We found both easy to navigate. In the front of the paper files, there was an index of where to find information. This meant there were opportunities to quickly reference information rather than seeking an available computer to access, especially in times of urgently requiring information.

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 were again pleased to find the same quality of care plans that evidenced the person’s involvement. We also found helpful information contained in people’s one-to-one discussions with their named nurse. We saw that physical health care needs were being addressed and followed up appropriately.

There was evidence of care plan reviews being undertaken and updated, reflecting the multidisciplinary meeting decisions and care goals, although we found that the care plan reviews would have benefitted from more detail.

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.

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

Continuation notes were on file for everyone on the ward, but these too could have provided more detail about the presentation of the person throughout the day. The format used in the ward is appropriate but lacks detail.

Recommendation 2:
Managers should ensure that continuation notes provide sufficient detail to inform the reader of the individual's presentation, interactions with those around them, and activities during the outgoing shift.

Discharge care plans were in place where relevant, and discharges were supported by an on-site discharge co-ordinator to reduce delays. On the day of our visit there were three people delayed, mainly due to awaiting appropriate housing/care placement and care at home provision.

We saw robust risk assessments in place using the traffic light system. These were easy to follow and there was evidence that these were updated in line with multidisciplinary team decisions.

Multidisciplinary team (MDT)

The ward has a broad range of disciplines either based there or accessible to them. The MDT used the standardised template to record meetings to good effect and there was a recording of the MDT meeting on MORSE. There were five consultant psychiatrists who provided input for those on the ward and MDT meetings were held over four days in the week. To ensure the consistency of recording of the MDT decisions, a member of staff was identified to attend all the MDT meetings and to action any follow up that was required. This member of staff was supernumerary to the staff on duty on the ward on the day of the meetings.

It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment was invited to attend the meeting and give an update on their views. Attendees were from the different professional backgrounds, from the nursing team, psychology, occupational therapy, social work, and any other auxiliary services involved with the person's care or discharge. The MDT meeting also included the person and their families, should they wish to attend. There were good links between the MDT decisions that were then followed up in the care plans. It was clear to see from these notes when the person was

moving towards discharge, or not, and that community services also attended the meetings as appropriate.

We were pleased to hear that psychology supported the nursing team in caring for people on the ward. We heard that some advanced nurse practitioners had provided tutorials for staff covering particular conditions or situations.

Use of mental health and incapacity legislation

On the day of our visit, six of the 16 people in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act).

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) should correspond to the medication being prescribed. All documentation pertaining to the Mental Health Act around capacity to consent to treatment was in place and completed appropriately.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. We did not see any recorded named person information.

Several people on the ward were subject to restrictions and decision making under the Adults with Incapacity (Scotland) Act 2000 (AWI Act).

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act 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. We found that two section 47 certificates, that were completed appropriately, did not have a treatment plan. We discussed this with managers and will look at this again when we next visit.

Recommendation 3:
Managers and medical staff should regularly audit section 47 certificates to ensure that treatment plans are completed and up-to-date.

One person was subject to covert medication arrangements. All appropriate documentation was in order.

On our previous visit we made a recommendation that the do not attempt cardiopulmonary resuscitation (DNACPR) status of every person should be known to all the staff providing their care. On this visit, we noted that one person had a DNACPR form in place, but it appeared that this had not been discussed with the family. We brought this to the attention of the charge nurse who agreed to action this.

Rights and restrictions

Ward 3 operates a locked door policy, commensurate with the level of risk identified in the patient group. Access to the ward is by buzzer entry from the outside and exit from the ward is by using an exit switch.

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 in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There were no specified persons on the ward on the day of our visit.

When we are reviewing individual records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under s274 and s276 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 advance statements on file. We will look at this again on our next visit.

On the day of our visit, there was one person subject to continuous intervention where they required an enhanced level of support.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

On the day of our visit, we saw people enjoying quiet time watching TV; there was a quiz taking place, and earlier in the day, there had been relaxation therapy and an exercise group. Later in the day, the activity nurse and some of the individuals on the ward were enjoying watching and dancing to music videos.

The activity nurse works five days out of seven; other activities were led by the occupational therapist. There was also a minibus that was used for outings. We were pleased to find that each individual had an activity plan on file.

The physical environment

The layout of the ward consists of single rooms and shared dormitories. There was a lounge area and a separate dining area, as well as a quiet room and an additional room, which was used as the MDT meeting room. All were bright and spacious. The environment was acceptable, but we felt that further work was needed to make the main areas more homely and welcoming.

The ward has 23 beds, including 11 single rooms. Some have toilets only and there are three four-bedded dormitory areas with toilet and shower. There is a large, assisted bathroom on the ward for use when it is more appropriate for people who would benefit from bathing rather than showering.

The ward has direct access to the outside space, which is in the process of being tidied up after the winter. New garden furniture was in place and some raised beds had been delivered

but were not yet planted up. We recognise the importance for people being able to access therapeutic outside space to aid their recovery and were pleased to see this was encouraged. There were photographs on the wall of when there was a visit from Pet Therapy and some that had people enjoying time with the Shetland ponies.

We noted the poster intimating the visit of the Mental Welfare Commission was displayed on a prominent place at the entrance to the ward. We saw information in the main corridor relating to advocacy services and carer support.

Summary of recommendations

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

Recommendation 2:
Managers should ensure that continuation notes provide sufficient detail to inform the reader of the individual's presentation, interactions with those around them, and activities during the outgoing shift.

Recommendation 3:
Managers and medical staff should regularly audit section 47 certificates to ensure that treatment plans are completed and up-to-date.

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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