Mental Welfare Commission for Scotland

Report on announced visit to:

Ward 20, University Hospital Hairmyres, 218 Eaglesham Road, East Kilbride, Glasgow, G75 8RG

Date of visit: 3 April 2024

Where we visited

Ward 20 is an adult acute psychiatric admission unit, based in the grounds of University Hospital, Hairmyres. It is a 26-bedded unit, divided into four dormitory areas with their own dedicated en-suite facilities and there are four en-suite side rooms. The unit provides assessment and treatment for adults who have a mental illness from the East Kilbride, Lanark and Clydesdale areas. On the day of our visit, there were 25 people on the ward, with one vacant bed.

We last visited this service in September 2019 and made recommendations around improving care plans and about the provision of activity co-ordinators. The response we received from the service in February 2020 was that peer audit reviews were established and that recommendations and accompanying action plans will be monitored through adult mental health governance structures, also that recruitment forms had been submitted for activity co-ordinators.

Who we met with

We met with, and reviewed the care of six people, two who we met with in person and four who we reviewed the care notes of. We also met with one relative.

We spoke with the service manager, the charge nurse and the senior nurse. We also spoke with the senior occupational therapist, the clinical psychologist and assistant psychologist.

Commission visitors

Anne Craig, social work officer

Margo Fyfe, senior manager

What people told us and what we found

We met with two people on the ward. One person wanted to tell us how nice and helpful the staff were. Another person said "staff are great, always helpful". A relative commented, "staff are great, communicate really well with me and have been very supportive, especially when my relative didn't want me involved at the beginning. They always make sure I'm okay too and look after my welfare".

We heard from the charge nurse that currently, the acuity of people's mental health in the ward is severe and we heard about the difficulties in supporting them in their recovery. Some difficulties arose due to people utilising time out and accessing alcohol and / or illicit substances. On returning to the ward, where they were under the influence of these substances, they can be disruptive to other people on the ward and upset the stability of the ward. We discussed strategies with the charge nurse and were advised that there is an intention to seek support from the local community Police team to visit the ward and, if appropriate, attend multi-disciplinary team meetings; this could provide a formal or informal police presence in and around the ward. We look forward to hearing about the implementation of this and about its success on our next visit.

We also spoke with the clinical psychologist and assistant psychologist who provide support to staff, as well as exploring people's behaviours and understanding the impact of this on the person and the staff caring for them. This can be provided on an individual or group basis. Staff are also trained to deliver lower-level psychological interventions. We heard that the assistant psychologist plans to provide more structured sessions to the staff and individuals on the ward.

On the day of our visit, there were people who were being cared for while on continuous interventions. We heard that hospital managers are supportive of using additional agency staff on the ward to support people when this is needed. This is crucial to ensure the safety and security of all persons on the ward and necessary in order to ensure that for those who are not on continuous interventions, they can receive support at the appropriate level.

We also heard that a number of the nursing team on the ward had only recently qualified as registered nurses. This could create concerns about the experience and skills of the nursing team. This is taken into consideration and reviewed regular by the service manager. On occasion there have been transfer of experienced staff members to support other areas.

We met with the senior occupational therapist (OT) for the ward and visited the mental health occupational therapy service, which was located nearby. This service has an art room, activity room and a kitchen. There was also a facility where people can do their laundry, an allotment area that was available and will be in use in the coming months where people can grow vegetables and cook them in the kitchen area. Supporting people with cooking in the kitchen area has been key to successful discharges and the team have a small budget for purchasing food. Home visits are undertaken prior to a person's discharge, to ensure that their home is suitable and they will be able to care for themselves. Referrals come from the multidisciplinary team and the nursing team and there was a three-day standard from referral to assessment. Most people are seen on an individual basis but group sessions are facilitated in some

circumstances. The occupational therapy service is also almost fully staffed, except for a vacant Band 3 support post.

Care, treatment, support and participation

Throughout the visit, we observed positive, compassionate and beneficial interactions between staff and patients, and staff we spoke with knew the patient group well.

The charge nurse, who was temporarily providing cover and was usually based in Ward 19, provided a high standard of care, demonstrating the skills and knowledge required of a team leader. We commented on this to the charge nurse, the service manager and senior nurse during our visit. However, we were aware that recruitment to senior staff posts on the ward is challenging. At the time of our visit, the ward was almost fully staffed with only one post for a healthcare support worker post due to be re-advertised.

Care records

Information on each individual's care and treatment was held 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. There was other information that was useful for quick reference, such as details and information about the GP, community psychiatric nurse and other key contacts. All the information contained in the paper files was available on MORSE. We found both easy to navigate. At 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 at times when information was urgently required.

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 detailed person-centred care plans that evidenced the person's involvement. People who had been recently admitted had an initial 72-hour care plan in place.

We did find that care plan reviews could have been more detailed. People were aware that reviews were taking place, but these were not fully reflected in the paperwork. We discussed this with the charge nurse, service manager and senior nurse the day of our visit and they were receptive to our comments. We suggested using the Commission guidance on our website to help with the process. 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 person's progress towards stated care goals and that recording of reviews are consistent across all care plans.

Discharge care plans were in place where appropriate and discharges were supported by an on-site discharge co-ordinator to reduce delays. On the day of our visit there were five people

whose discharge from hospital was delayed, mainly due to a wait for the appropriate housing/care placement and care-at-home provision.

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.

Chronological notes were recorded on the situation, background, assessment, and review (SBAR) format. We were told that for quality assurance purposes, the SBAR format may change to ensure a standardised format is used across all mental health services in NHS Lanarkshire area. We look forward to seeing these changes on our next visit.

We saw robust risk assessments that were updated in a timely manner and were detailed using a traffic light system.

Multidisciplinary team (MDT)

The ward has a broad range of disciplines involved in the multidisciplinary team (MDT) either based there, or accessible to the ward. The MDT consists of psychiatry, psychology, nurses, occupational therapy and a peer support worker. There is access to pharmacy, dietetics and wider professions on referral. Social workers regularly visit the ward and advocacy support is provided from the local service.

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 providing input to those on the ward at the time of our visit, and MDT meetings took place on three days of the week. To ensure consistency of recording of the MDT decisions, a member of staff was identified to attend all the MDT meetings and action any follow up that was agreed. 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 each individual's care and treatment was invited to attend the meetings and give an update on their views. Attendees were from the clinical and nursing teams, psychology, occupational therapy, social work and any other auxiliary services involved with the person's care or discharge. The MDT meeting also included the individual 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 when the person was moving towards discharge, or not, and that community services were also attended the meetings, as appropriate.

Use of mental health and incapacity legislation

On the day of our visit, 16 of the 25 people in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). The people we met understood their detained status, where they were subject to detention under the 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 relating to the Mental Health Act around capacity to consent to treatment was in place in the paper files, but we found that authority to treat four people under Part 16 of the Mental Health Act required updating. When we brought this to the attention of the charge nurse, they agreed to raise this immediately with the responsible medical officer (RMO) for urgent action.

Recommendation 2:
Managers should ensure that where a person is subject to Mental Health (Care and Treatment) (Scotland) Act 2003 that the appropriate consent to treatment forms (T2) and authority to treat forms (T3) are completed accurately and are up-to-date.

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 named person paperwork in the files we viewed.

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 (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. People subject to AWI Act 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 two people had a s47 certificates in place, which were completed in line with the legislation.

Rights and restrictions

Ward 20 operates a locked door, commensurate with the level of risk identified in the patient group. Exiting from the ward could be done by using a switch next to the door, and access was by buzzer entry from the outside.

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 person is specified under these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. On the day of our visit, five people were specified. All appropriate paperwork was in place, along with reasoned opinions.

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 spoke with the charge nurse who confirmed that they do try to encourage people 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 people 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

Ward 20 has a dedicated peer support worker who works a five out of seven days, and during our visit we saw them engaging people in activities such as dominoes and colouring in. We also heard about a recent invitation to local community groups for an open day where people could hear about local services they could engage with, and local groups are encouraged to visit the ward to provide services. Most of these groups are staffed by volunteers. We heard about the local Men's Shed, Beacons in Blantyre, a Handyman service and a walking group led by Lanarkshire Association for Mental Health (LAMH). We heard that Pet Therapy is a regular visitor to the ward and this has been extended to including some Shetland ponies visiting the ward.

We were told that staff on the ward try to provide meaningful activity for people when this does not compromise the clinical and nursing care of the ward population.

On our previous visit, we made a recommendation for the recruitment of an activity co-ordinator. We were advised following our visit in 2019 that recruitment for this post was in hand. We are disappointed to note that to date, this has not been progressed. We believe that a dedicated activity co-ordinator for the ward would be beneficial for those in the ward, and would complement the work of the peer support worker.

Recommendation 3:
Managers should consider progressing the provision of an activity co-ordinator to the ward.

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. There was a quiet room and an additional room that was used as the MDT meeting 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.

On the day of our visit, work was being undertaken in the ward below replacing the windows to comply with reduced ligature legislation. At times, the noise from this upgrading was unbearable. Whilst it is acknowledged that this work is urgently needed, and the same work is required to be completed in Ward 20, it could be to the detriment of some of the people who are currently in the ward; resting whilst this level of noise permeates the ward could be difficult.

The ward has no direct access to the outside space. We consider that it is important that people can access therapeutic outside space to aid their recovery. Currently access is down stairs and through an external door. This is not ideal but due to the location of the ward, no other options are currently available.

Any other comments

On leaving the building, we noted the strong smell of cigarette smoke at the exit area. This is because people from the wards who wish to smoke do so at the entrance area; it was especially pungent on the day of our visit as the weather was inclement and people were sheltering just inside the canopy at the door entrance. The reception area is located right at

the entrance to the building and reception staff should not have to experience the effects of cigarette smoke during their working day. All NHS buildings are now non-smoking within 15 metres of the building and this can result in £50 on the spot penalty or £1000 fine if the offence leads to a prosecution. We would urge managers to look at how this issue can be managed.

Summary of recommendations

Recommendation 1:
Managers should ensure care plan reviews are audited to ensure constancy and clarity around content, actions and progress.

Recommendation 2:
Managers should ensure that where a person is subject to Mental Health (Care and Treatment (Scotland) Act 2003 that the appropriate consent to treatment forms (T2) and authority to treat forms (T3) are completed accurately and are up-to-date.

Recommendation 3:
Managers should consider progressing the provision of an activity co-ordinator to the ward.

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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