Mental Welfare Commission for Scotland

Report on announced visit to: Hairmyres Hospital, Wards 19 and 20, 218 Eaglesham Road, East Kilbride, Glasgow G75 8RG

Date of visit: 24 February 2016

Where we visited

Wards 19 and 20 are adult acute psychiatric admission units based in the grounds of Hairmyres District General Hospital. Both wards have similar layouts. Ward 19 has 30 beds and Ward 20 has 25 beds.

We last visited this service on 11 February 2015 and made recommendations relating to nursing time, consultant psychiatry input to the ward, access to psychology, patient smoking and storage space in bathrooms.

On the day of this visit we wanted to follow up on the previous recommendations and also look at case records. This is because we are aware that although there is an electronic records system in place, MIDIS, there are some difficulties experienced by staff in using the system.

Who we met with

We met with 13 patients.

We spoke with the charge nurses from each ward, the service manager, an occupational therapist and an advocacy worker.

Commission visitors

Margo Fyfe, Nursing Officer & visit co-ordinator

Mike Diamond, Executive Director (Social Work)

Moira Healy, Social Work Officer

Dr Mike Warwick, Medical Officer

What people told us and what we found

Care, treatment, support and participation

Case Records

The electronic system in place is MIDIS. All disciplines contributing to patient care are expected to write notes on this system. We found the system slow to use and heard that staff are frustrated by the length of time writing in records can take due to this issue.

We were pleased to see that care plans were person-centred and reflected the current support being provided to patients. However it is not clear from the care plan when a review had taken place, what progress the patient has made. We suggest that on review the notes should reflect what has changed for the patient and what new support is to be actioned.

The multidisciplinary care reviews seen were clear and noted all in attendance. However we were informed that some of the psychiatrists wrote up their reviews in the continuation note section of the electronic record rather than the MDT review section. This meant it took quite some time to locate these notes in the file. We recommend that all review notes are written in the correct area of the electronic case file. It was good to see consistent recording of nursing one-to-one time with patients and it is of note that patients seen said they valued this time with nursing staff.

We were shown the paperlite files for the patients seen on the visit. These files contained legal documentation and letters from other clinicians/agencies as well as continuing care notes when the electronic system is not in operation. We recommend that all letters are transferred onto the electronic system as well as being in the paperlite files to ensure that anyone reading the electronic file has access to all relevant information.

Recommendation 1:

Managers should ensure that care plan reviews reflect what has been reviewed, patient progress and changes to support.

Recommendation 2:

Managers should ensure that multidisciplinary review notes are written in the correct section of the electronic case record.

Recommendation 3:

Managers should ensure that all relevant information regarding a patient is transferred onto the electronic case record to ensure ease of access to all patient information.

Nursing time

On our last visit we heard that nurses were frustrated by the amount of time they spent on cleaning in the ward and on writing up patient notes due to the slowness of the electronic system. These issues took away from direct patient interaction time. Following that visit we were informed that there are continuous reviews of the demands of nursing time including utilising Releasing Time to Care initiatives and applying the national nursing workforce tool.

During this visit we were told that these concerns are still there and that the national workforce nursing tool is due to be run again in the wards in March 2016. We would expect that findings from this exercise are discussed timeously by managers and that any staffing needs are promptly addressed to ensure patients benefit.

Recommendation 4:

Managers should use the results of the workforce planning exercise to address any staffing needs in the wards to ensure benefit to patient care.

Provision of consultant psychiatrist cover

At the time of our last visit we heard that at any one time there can be up to ten consultant psychiatrists attending the wards. We were also told that with ward closures in Monklands General Hospital and Wishaw General Hospital wards 19 and 20 were noting an increase in patient admissions. When patients from the other hospitals in Lanarkshire are admitted to the Hairmyres wards there are two consultant psychiatrists who rotate cover to the ward on a Friday to see these patients. This can lead to a wait of six days for a patient to be seen by a consultant psychiatrist. We had recommended that a review be undertaken of the provision of consultant psychiatry cover across the area.

Although we were told that consultant cover has not changed we noted that patients seen felt they had good contact with their consultant psychiatrist. However staff time is still taken up by many consultant reviews. We are keen to hear how the review has progressed and the outcomes when available.

Access to psychology

When we last visited we were informed that referrals had to be made to psychology and that patients would be put on the waiting lists which may mean they would not be seen during their admission.

We were informed that although referrals still have to be made to psychology as there is no dedicated psychology service for the wards that patients are seen reasonably quickly. We also heard that nurses can offer low level psychological interventions on a group basis e.g., anxiety management, mindfulness, Mywrap recovery focus group and a hope group. We also heard that the hospital Chaplin attends the wards weekly to carry out a mindfulness group and a hope group.

Prescriptions of 'if required' medications

For two patients we noted that medical staff had written prescriptions of "if required" medication with a dosage interval, but without a maximum daily dose. This is necessary for safe prescribing.

Recommendation 5:

Doctors should include a maximum daily dose on prescriptions for "if required" medication, and pharmacists should check this when they audit prescriptions.

Use of mental health and incapacity legislation

There were 16 patients subject to detention under the Mental Health (Care & treatment) Act 2003 between the two wards at the time of our visit.

Other than in one case, we found all relevant legal documentation easily in the paperlite patient files. We particularly liked the use of the information sheet detailing dates of detention and any other relevant dates e.g. consent to treatment forms.

Rights and restrictions

Of the patients seen we found reviews of any that were on enhanced observations to be up to date along with relevant risk assessments. Patients said they felt involved in their care decisions and planning.

Activity and occupation

There is a peer support worker who spends 20 hours per week between the two wards. He spends time directly with patients on one-to-one and group activity and support. Nursing staff provide group work when they can and the occupational therapy staff spend time on assessments and getting patients off the ward in preparation for discharge.

The patients we met with highly praised the peer worker, nurses and occupational therapy staff. Some of the patients specifically commented that they were engaged in activities that were useful to them as individuals.

The physical environment

The wards are clean and bright. They are laid out on the same way as the general wards elsewhere in the hospital.

In previous visits we have commented on the patients using the front entrance area to smoke. We note that there is clear signage in place stating that there is no smoking permitted on hospital premises. However, patients continue to smoke as before in the entrance area. We were informed that a voice activated message is being installed at the entrance to discourage smoking. We were also told that all staff discourage patients from smoking at the entrance and that there is also smoking cessation staff available in the wards. The staff ensure patients are given every opportunity to stop smoking whilst in-patients.

We heard that the smoking policy states that staff are not to accompany patients for the purpose of smoking. We are aware this can be an issue for detained patients who wish to continue to smoke. However we were told that patients who are detained are mainly accepting of the restriction on smoking. Should a patient choose not to comply with the restriction when detained the consultant psychiatrist in charge

of their care will be informed to assist in ensuring the patient understands the no smoking rules for in-patients.

Storage space in bathrooms

A recommendation made during our last visit related to storage space in the bathrooms for patients to put their belongings whilst bathing. We were pleased to see that shelving had been provided and was in use for toiletries. However, we found that there is still nowhere for patients to put their clothing. We were told that shower chairs could be provided for this purpose. We would expect to see this in place on future visits.

Summary of recommendations

1. Managers should ensure that care plan reviews reflect what has been reviewed, patient progress and changes to support.

2. Managers should ensure that multidisciplinary review notes are written in the correct section of the electronic case record.

3. Managers should ensure that all relevant information regarding a patient is transferred onto the electronic case record to ensure ease of access to all patient information.

4. Managers should use the results of the workforce planning exercise to address any staffing needs in the wards to ensure benefit to patient care.

5. Doctors should include a maximum daily dose on prescriptions for “if required” medication, and pharmacists should check this when they audit prescriptions.

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

Mike Diamond
Executive Director (Social Work)
13 April 2016

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 MWC 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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