Mental Welfare Commission for Scotland

Report on announced visit to: Western Isles Hospital, Adult Psychiatric Unit and Clisham Ward, MacAulay Road, Stornoway, Isle of Lewis HS1 2AF

Date of visit: 29 November 2016

Where we visited

The Adult Psychiatric Unit (APU) is a five bedded ward catering for acute adult psychiatric admissions.

Clisham ward is a 10 bedded ward (with two contingency beds) for older adults with a focus on dementia care. Both wards provide en-suite facilities within a general hospital setting.

We last visited these services in October 2015. On the day of this visit we wanted to follow up on the previous recommendations, which were that rights information should be accessible, staff should learn from one case seen of apparent unlawful detention, psychology input should be reviewed, and appropriate care for the needs of learning disabled patients should be provided. We also recommended an environmental audit of Clisham to improve dementia friendliness, improvement of personalisation in Clisham, an audit of the APU to remove ligature points, and improvement in occupational therapies (OT) input to both wards.

Who we met with

We met with and/or reviewed the care and treatment of six patients. No carers, relatives, or friends were available to be seen on the day of our visit.

We spoke with the Clisham charge nurse on the day, as well as other nursing staff, and met the associate director of mental health and learning disabilities, and the senior charge nurse for mental health in patient services on the following day.

Commission visitors

Tony Jevon, Social Work Officer

Kate Fearnley, Executive Director (Engagement and Participation).

What people told us and what we found

Care, treatment, support and participation

In the APU, the patients confirmed what nursing staff had told us: that the care team were good at involving relatives in care planning. Notes showed evidence of a good amount of one to one interaction with staff. One patient told us "there is a lovely activity room on the ward", and was happy with all the care and treatment offered and involvement in care and discharge planning.

There was a calm atmosphere in both wards, and we observed warm and friendly interactions taking place between nursing staff and patients.

In Clisham, ‘Do Not Attempt Cardiopulmonary Resuscitation’ paperwork was in place as appropriate, and discussions had been held and recorded with relatives.

Where it had been deemed necessary to use covert medication, the Commission’s pathway was in place.

However, in Clisham, we found poor personal information available in the notes. ‘Getting to know me’ and other life story work had not routinely been completed.

Recommendation 1:

Managers should ensure that ‘Getting to know me’ and other life story work is fully completed and should audit to see that this is done. In one case, a patient who was cared for mostly in bed had a radio in their room tuned to a general music station. Staff we spoke to were unaware of the patient’s preference for country and western music even though it was recorded in the nursing notes. The care plan for this patient was to offer a sensory stimulation session of 15-20 minutes a week. We thought more could be offered to this patient, and we spoke to the charge nurse about this.

In Clisham it was also difficult to find evidence of discharge planning - staff reported making referrals to social work with no result. In one case the patient was admitted in 2009 for 'a period of extended assessment'. The social work team told us that they believed everyone referred to them had been allocated a social worker and discharge planning was underway. Given that this is quite a small, and now integrated, service we thought communication could be better and spoke to the senior charge nurse about following up in this case.

Recommendation 2:

The ward manager should link with the social work team responsible for patients’ care management to ensure that discharge planning, including a review of the need for welfare guardianship where relevant, should be progressed at least quarterly and should develop a system for clearly documenting actions and outcomes from the discharge review meetings in the patient’s file.

Use of mental health and incapacity legislation

Adults with Incapacity Act guardianship, power of attorney and s47 treatment certificates were in place. There was evidence of good contact with guardians and attorneys at appropriate times.

Rights and restrictions

We were pleased to see that concerns raised in 2015 about appropriate use of the Mental Health Act to authorise detention in Clisham ward had been addressed.

Activity and occupation

In 2015 we identified from notes that there was little evidence of any planned activity for patients, and asked that this be reviewed with OT services. We were told that this review had highlighted gaps. We saw from notes that some patients in Clisham have as little as 15 minutes per week one to one time with nursing staff.

Recommendation 3:

Managers should review how activities are provided, and ensure patients are offered adequate activities to meet their needs.

The physical environment

We were disappointed that little had been done in response to our recommendations about the environment in Clisham ward from last year apart from that some photos had been put up in rooms and that after discussions with infection control staff, patients in the single rooms could now have their toiletries on open shelves to support them to access these independently.

A ligature survey of APU had been done in the last week.

Wardrobes had been removed for safety reasons from bed areas after an incident in another hospital area. Patients now only had small cupboards, insufficient for long stay patients on Clisham ward. The wardrobes were now stored en masse in a lounge area, to which ambulant patients would have access. This situation did not seem to have significantly reduced any safety concerns, but had impacted on quality of life issues for patients.

Recommendation 4:

Managers should resolve how to provide safe and sufficient storage of clothes in patient bed areas with health and safety staff.

Summary of recommendations (for Clisham)

1. Managers should ensure that ‘Getting to know me’ and other life story work is fully completed and should audit to see that this is done.

2. The ward manager should link with the social work team responsible for patients’ care management to ensure that discharge planning, including a review of the need for welfare guardianship where relevant, should be progressed at least quarterly and should develop a system for clearly documenting actions and outcomes from the discharge review meetings in the patient’s file.

3. Managers should ensure activity care plans are person centred reflecting the individual’s preferences alongside activities specific to their care needs.

4. Managers should resolve how to provide safe and sufficient storage of clothes in patient bed areas with health and safety staff.

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

Kate Fearnley

Executive Director (Engagement and Participation)

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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