Mental Welfare Commission for Scotland

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

Date of visit: 22 November 2017

Where we visited

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

Clisham ward is a six-bedded ward (with one contingency bed) 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 November 2016. Clisham was also visited unannounced in March 2017. On the day of this visit we wanted to follow up on the previous recommendations. These were that life story work is fully completed, discharge planning should be clearly documented, all care plans should be person-centred, covert medication pathway should be followed, do not attempt cardiopulmonary resuscitation (DNACPR) paperwork audited. Also, that safe and sufficient storage of clothes in patient bed areas should be provided.

The manager of the service had written to the Commission to update us on progress with these recommendations. Life story work has been completed where information has been accessible. Discharge planning is now recorded clearly on the electronic patient records system. They are developing an audit tool on recovery based care plans with their Scottish Patient Safety Programme facilitator. Covert medication pathways have been added to patient case notes and medication prescription sheets, and DNACPRs are now checked at the weekly ward round.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and spoke to one relative who was available on the day of our visit.

We spoke with the one senior charge nurse on the day, as well as other nursing staff, and met the associate director of mental health and learning disabilities.

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 feedback from the patients we spoke to about their care and treatment was very positive. They were aware of, and in some cases had exercised, their legal rights and said 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 the staff are 'brilliant', including medical, nursing, auxiliaries and domestics.

In both wards there was a calm atmosphere and we observed warm and friendly interactions taking place between nursing staff and patients. Assessment paperwork seen covered emotional and physical assessments and had good person-centred detail. In conversations we found evidence the staff know the patients well, and multi-disciplinary team ward review notes were clear.

Last year we recommended the ward manager of Clisham 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, was progressed at least quarterly. Also, a system for clearly documenting actions and outcomes from the discharge review meetings in the patient's file should be developed.

This year we asked for clear information about which of the Clisham patients were formally on the delayed discharge list. The senior nurse and doctor on duty did not have this information and could not tell us what actions were being taken to plan the discharge of patients who no longer needed hospital care.

We also found in notes, and speaking with a relative, that relatives felt they had not been informed of discharge plans and the plans for Clisham ward closure.

The ward manager told us the information was not in the patient's file but available electronically. We were reassured that the senior hospital staff and the Western Isles social work team were working closely to identify discharge accommodation. Social workers have been allocated and assessments are being carried out or are completed.

We also raised this issue when we met with hospital managers and learnt that some information about the hospital plans had been shared at public events.

Recommendation 1:

The Associate Director of Mental Health should communicate directly with patients, family and friends and carers to ensure they know what the plans are for their discharge, and for the hospital ward. Staff on the ward should be able to tell patients, family and friends and carers what the plans are for each individual, and involve them in discharge care planning.

Use of mental health and incapacity legislation

In Clisham, DNACPR paperwork was in place where appropriate, and discussions had been held and recorded with relatives. Although, the paperwork did not always reflect their role as power of attorney or legal guardian. This was also true of the covert medication pathways. There was no detailed information about relatives who had legal authority, and no agreement about when they wanted to be contacted, what decisions they were involved in and what powers they had.

Recommendation 2:

Managers should implement the use of an Adults with Incapacity (Scotland) Act 2000 (AWI) front sheet that records all the information necessary about legal proxies. It should be used to ensure that these proxies have agreed to treatments, and other legal paperwork, such as DNACPRs.

Rights and restrictions

Activity and occupation

In the APU we found evidence of activities available for patients, and close involvement with occupational therapy and psychology. Patients we spoke to confirmed they were offered and took part in a range of activities. Some had in-reach support from community workers. In Clisham, there is an activities board in the corridor that shows the weekly programme, and nurses highlight interventions in patient notes. We did not think some of the activities highlighted should have counted as such, for example where people watched TV/listened to the radio/were visited by a relative. However, we saw nurses interacting on a one-to-one basis with patients throughout our visit.

The physical environment

Bed spaces are personalised. As patient numbers are being reduced the large dayroom in Clisham is now not used and a pleasant space has been made in another room instead. Toilet signage is partial. Some toilets have an internal door, which could benefit from another sign. Although, staff advised that most patients require assistance anyway, but agreed that some might be able to use toilets independently, some of the time, and they will look at this. Toilet seats are not contrasting. Wardrobes removed for safety reasons over a year ago, since an incident, are now in a locked space so patients remain unable to access them directly. We heard that this is not a major inconvenience for most patients, and it is unlikely that money will be spent on this when the ward is due for closure.

There is a pleasant garden, refurbished this year, and used in good weather but not unsupervised due to falls risk. The Solardome was in use this summer for tomatoes, but still not repaired for patients' use since our last visit. Staff are trying to find someone to do this as the works department have indicated they see it as low priority.

The APU has a good activity room and an attractive comfortable lounge. Two bedrooms are to be upgraded to a higher standard soon as part of the planned reduction in beds in the APU.

Summary of recommendations

We have no recommendations for the APU. The recommendations below are for Clisham ward.

1. The Associate Director of Mental Health should communicate directly with patients and relatives to ensure they know what the plans are for their discharge, and for the hospital ward. Staff on the ward should be able to tell patients and relatives what the plans are for each individual and involve them in discharge care planning.

2. Managers should implement the use of an AWI front sheet that records all the information necessary about legal proxies. It should be used to ensure that these proxies have agreed to treatments, and other legal paperwork, such as DNACPRs.

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.

Alison Thomson
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 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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