Mental Welfare Commission for Scotland

Report on unannounced visit to: Ward 2, Wishaw General Hospital, Netherton Road, Wishaw ML2 0DP

Date of visit: 16 February 2017

Where we visited

Ward 2 is a care of the elderly admission and assessment ward for people suffering from various mental illnesses excluding dementia. It is a 23 bedded mixed sex unit in the mental health department of a district general hospital. The ward opened in the summer of 2016 following the closure of wards in Coatbridge Hospital and Airbles Road Clinic. Prior to the ward opening and patients being transferred, staff participated in teambuilding sessions to work towards establishing the new ward team.

The ward has five consultant psychiatrists who hold their review meetings on four days of the week. There is psychology input one day per week providing staff training and direct patient contact. At present, the occupational therapy post is vacant and will be recruited to and the activity co-ordinator role is being explored further with managers. There are nursing vacancies which are being recruited to but we heard that there had been a shortage of nursing staff, which had meant there had been regular use of bank staff. We were informed that there is improved access to dietetics, physiotherapy and physical health investigations now that the patients are on the general hospital site. This was our first visit to this new ward.

Who we met with

At the time of our visit there were 13 patients on the ward. We met with and/or reviewed the care and treatment of eight patients.

We also spoke with the senior charge nurse and several of staff nurses.

Commission visitors

Margo Fyfe, Nursing Officer

Moira Healy, Social Work Officer

Graham Morgan, Engagement and Participation Officer

What people told us and what we found

Care, treatment, support and participation

Electronic case file system (MIDIS)

The care plans, multidisciplinary reviews, risk assessments and continuation notes are held on the electronic system MIDIS. This system is slow to navigate and we heard, as in previous visits within the health board area, that nurses are of the view the system takes time away from patient contact. We are keen to know if there are any plans to improve this record system in the future to ensure efficiency and lessen any impact on nurse/patient time on the wards.

Care Plans

Although all patient files reviewed had care plans in place, we found these to be inconsistent. In some cases all the care plan information was held in one care plan, but in others this was split over several care plans as we would hope to see. We found reviews lacking enough detail about the patient's progress in each area of their care plan.

Recommendation 1:

Managers should audit care plans along with the senior charge nurse to ensure consistency, clarity of information and evidence progress of the patient during their in-patient stay.

Multidisciplinary reviews

We were pleased to see that multidisciplinary reviews were informative and gave clear information on progress and forward plans. It was good to see that attendees were noted, and that patients and families were kept informed of the outcome of meetings if not in attendance.

We were pleased to see the attention to physical health care needs from the multidisciplinary team.

Use of mental health and incapacity legislation

We found all legal documentation for the Mental Health Act and the Adults with Incapacity Act within the paper light files for each patient this related to. Consent to treatment certificates under each Act (T2/T3 and S47) were held with the medicine prescription sheets and were all up to date with current treatment.

Rights and restrictions

On the day of the visit the main door to the unit was locked. We were informed this was due to a patient who had a dementia diagnosis tending to leave the ward. We checked the patient was detained and that other patients had been informed of the reason for the door being locked. Staff were available to open the door for patients when they wished to leave the ward. We also praised the good practice of ensuring there was a sign on the door explaining the situation to patients and visitors.

Activity and occupation

Some of the patients we met with said that they were often bored as there was not much to do on the ward. We heard that there had been an activities nurse who had been absent for a time but that since her return had been working in another ward. The senior charge nurse assured us the need for an activity co-ordinator on the ward

was being discussed with managers with a view to providing this role to the ward again. We are keen to hear when and how this issue is resolved. In the meantime, we would expect to see nurses on the ward incorporating activities for the patients as part of their care role on the ward.

Recommendation 2:

Managers should review the activity co-ordinator provision in the ward and inform the Commission of how and when this situation is improved.

The physical environment

Although bright and clean, the ward is very clinical. There is a lack of soft furnishings and pictures in communal areas. We heard that there is difficulty controlling the temperature, and urge managers to discuss this with the appropriate department to ensure patient comfort.

Patients also commented that it would be helpful to have some form of signage that indicated the day, date and weather, as they felt that they often lost track of time when they were inpatients. Managers should be consider this when thinking about how to make the ward less clinical.

There is a large enclosed garden space that patients can use. However, this can only be accessed via a room that is used for meetings or visitors. We urge managers to consider how to better use space on the ward to ensure that patients can access the garden space when they wish, without being impeded by meetings.

Recommendation 3:

Managers should consider how to make the ward less clinical and ensure that issues in regard to the heating system and access to the garden area are addressed promptly.

Any other comments

The people we met with said they felt supported by staff and that their families were made to feel welcome on the ward.

However, it was brought to our attention that some patients with a functional illness struggle with the patient mix on the ward. We are aware that there is a ward next door that is for patients with a dementia diagnosis, but that when these beds are full, patients will often be boarded in Ward 2. We heard that the two patient groups, functional mental illness and dementia illnesses, have differing needs and that at times staff can be stretched trying to ensure all needs are met. We suggested that managers give further consideration to the patient mix to ensure maximum benefit to all patients.

Summary of recommendations

1. Managers should audit care plans along with the senior charge nurse to ensure consistency, clarity of information and evidence progress of the patient during their in-patient stay.

2. Managers should review the activity co-ordinator provision in the ward and inform the Commission of how and when this situation is improved.

3. Managers should consider how to make the ward less clinical and ensure that issues in regard to the heating system and access to the garden area are addressed promptly.

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)

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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