Mental Welfare Commission for Scotland

Report on announced visit to: Ailsa Ward, Stobhill Hospital, Balornock Road, Glasgow, G21 3UW.

Date of visit: 29 June 2021

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with the Scottish Government's route map (May 2020). There have been periods during the pandemic where we have been unable to conduct our face-to-face visits; however this local visit was able to be carried out face-to-face.

Ailsa ward is a 20-bedded rehabilitation ward, principally serving patients from the North-East catchment area of Greater Glasgow and Clyde Health Board. On the day of our visit there were 20 patients in the ward. The ward comprises of 12 single rooms and two four-bedded dormitories. We last conducted a local visit to this service in October 2016. We also visited there as part of our themed rehabilitation in mental health visit in 2018.

Following our 2016 visit we made two recommendations relating to activity planning and the availability of therapeutic recovery-based groups.

On the day of this visit we wanted to follow up on the previous recommendations and also hear how the service had managed throughout the current Covid-19 pandemic, specifically in relation to the impact of restrictions, contact with relatives, reductions in opportunities for rehabilitative activities out with the ward and the mental health of patients. We also wanted to give patients an opportunity to raise any issues with us and to ensure the care, treatment and facilities are meeting patients' needs.

Who we met with

We met with and reviewed the care and treatment of seven patients and spoke with two sets of relatives.

We spoke with the senior charge nurse (SCN), a charge nurse, and various other members of nursing staff on the day of the visit.

Commission visitors

Lesley Paterson, Nursing Officer

Mary Hattie, Nursing officer

What people told us and what we found

At the time of our visit the ward was at full capacity with 20 patients. Many of the patients have complex needs and have been in hospital for a number of years. Some patients are quite mentally unwell and others have considerable physical health needs. There are particular challenges in providing care for such a diverse group of patients and meeting their very different needs; however we heard from nursing staff that they feel supported and equipped to do so.

Care, treatment, support and participation

The patients and relatives we spoke to were generally very positive about the care and treatment provided and spoke highly of the clinical team. They report that staff are friendly, approachable, professional, and really seem to care.

Many patients have been in hospital for a considerable number of years and the chronic nature of their illness means their ability to engage and participate in activities of daily living, therapeutic, social and recreational activities can be limited. We did, however, see evidence of considerable efforts by nursing, occupational therapy (OT) and psychology staff to encourage engagement in both their treatment and activities.

The ward has input from one consultant psychiatrist, OT, psychology and pharmacy. Input from other professionals including dietetics, speech and language therapy, physiotherapy and podiatry can be arranged on a referral basis. We were told that the psychology input is really valued, especially with regards to the weekly patient formulation sessions which they facilitated. Staff find these really helpful in gaining an understanding of their patients, and a deeper understanding of their presentations and distressed behaviours. The psychologist is currently on leave and at the time of our visit there was no psychology provision. We would be keen to hear from managers what contingency they plan to put in place to address this deficit.

There is a visiting GP service which provides three sessions per week and the ward also has access to the Duty Doctor when required. All annual health checks are carried out along with any other required physical healthcare interventions including Clozapine and Lithium therapy bloods, high dose antipsychotic monitoring, diabetic monitoring, and general wound care including leg dressings. In addition, pharmacy staff are available for consultation, completion of medication reviews and will spend time with patients discussing their medication as required.

Multidisciplinary team (MDT) meetings are held weekly and each patient is discussed and reviewed a minimum of once every four weeks, but more frequently if required. Decisions and actions were recorded clearly and there was documented evidence of patient involvement and regular communication and consultation with families and carers, where appropriate. There was a range of MDT professionals involved and it was clear to see who attended each meeting.

Risk assessments were robust and regularly reviewed. There was a clear link between risk and care and treatment. Care plans were person centred, detailed, responsive to needs, and there was evidence of patient involvement and regular review. There was a big focus on aspects of

daily living skills and promotion of independence. We also found detailed assessment and care planning for physical health care needs. We were pleased to see very good rehabilitation assessments and formulation of rehabilitative needs within the files.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We were told that advocacy input is available on request and that the patients who use this find it valuable and supportive.

A significant issue for patients and families across Scotland has been maintaining contact during the Covid-19 pandemic due to national restrictions on hospital visiting. Ailsa staff have encouraged family contact as far as possible and some patients have been able to maintain telephone or video call contact where appropriate with a move towards face-to-face when restrictions allowed. Prior to the Covid-19 pandemic, informal work with carers was taking place and there were considerations into making this more formal, perhaps with the inception of a dedicated carer nurse. Although engagement with carers was impacted due to the Covid-19 pandemic, we would hope this carers support structure can be further explored and formalised as we emerge from the pandemic. We look forward to seeing how this has progressed at future visits.

Use of mental health and incapacity legislation

Fifteen of the twenty patients on the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Where individuals were subject to detention under the Mental Health Act, all relevant current detention paperwork was present in the files.

Part 16 (S235-248) 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. Certificates authorising treatment (T3) under the Mental Health Act were in place where required, however a number of these certificates did not cover all medication prescribed. When the Responsible Medical Officer (RMO) wishes to prescribe a medication outwith that covered in the current T3 they should contact the Commission to arrange a review by a designated medical practitioner. This was brought to the attention of staff at the time of the visit.

An advance statement is written by someone who has been mentally unwell. It sets out the care and treatment they would like, or would not like, if they become ill again in future. Only two of the patients currently in Ailsa have an advance statement. We suggested these could be better promoted but understand that some patients choose not to complete one.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), this was recorded. Where individuals were subject to

guardianship or a guardianship application had been made, we found copies of the powers and relevant paperwork within the files we reviewed. Where individuals lacked capacity to make decisions about their health care, section 47 certificates, which authorise treatment under the AWI Act, were in place and for those patients whose funds are managed under Part 4 of the AWI Act, all relevant paperwork and spending plans were in place.

Recommendation 1:

Managers should review all current T3 certificates ensuring medical staff pursue DMP visits urgently.

Recommendation 2:

Managers should put an audit system in place to ensure that all medication prescribed under the mental health act is legally authorised.

Rights and restrictions

The ward doors are locked and controlled by keypads. There is information on how to access and exit the ward on display. The current level two Covid-19 restrictions mean that patients are allowed to have two designated visitors. Visits must be booked in advance. We heard that the ward is flexible around visiting times and has adequate space to support the level of visit requests currently received.

Due to the Covid-19 restrictions time out with the ward is restricted, with time out being routinely limited to 90 minutes within the hospital grounds. However, longer time out and home visits to support discharge planning are risk assessed and authorised on an individual basis, with plans in place to ensure compliance with current restrictions and to minimise risk. On some occasions. patients who are out with the ward for a period of time longer that 90 minutes are required to self- isolate in a side room for a period of five days, to ensure they are Covid-19 free prior to mixing with the ward population. We explored the current time out policies with senior management and, while we appreciate the rationale for having such procedures to be in place, we will raise our concerns with certain restrictive aspects of these with the relevant Head of Mental Health Services.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients 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

Therapeutic activity and occupation

On our previous local visit to Ailsa, we made two recommendations relating to activity planning and the availability of therapeutic recovery-based groups. We were pleased to see that every patient has an individualised activity planner tailored to their preferences and rehabilitative needs. We saw evidence of regular activities being undertaken on a one-to-one and small group basis within the care plans we reviewed. The ward have OT input; however, a full time member of OT staff is currently on long-term leave with the post remaining unfilled

during this time. Despite this, it was clear to see that nursing and the remaining OT staff were working hard to offer a full and varied programme of activities. We were surprised to hear that Ailsa does not have access to a therapeutic activity nurse (T.A.N.). We have recently visited other wards within the Stobhill site and have been impressed by the positive impact this provision had made to patients, especially throughout the Covid-19 pandemic. We would urge managers to reconsider this position, especially in light of the OT team currently being depleted.

Recommendation 3:

Managers should ensure that the rehabilitation service receives dedicated TAN provision commensurate with that provided to other wards on the hospital site.

The physical environment

The ward is bright, spacious, and clean, in good decorative order and has a lot of natural light. It is nicely furnished and has two day rooms, a dining room, a large activity/ multifunctional room, a therapeutic kitchen, a pool room, a patient's pantry with tea making facilities, a patient's laundry with washing machines and tumble dryers, an MDT/ staff training room and a visiting room. There is a well-designed, well maintained secure garden to the rear and an outside seating area to the side of the ward. Both of these areas are peaceful, pleasant and used regularly by patients. Beds are located in 12 single rooms and two four-bedded dormitories.

Many wards across NHSGGC have been refurbished to provide patients with individual rooms and we would strongly encourage managers to consider the same here to ensure privacy and to protect dignity, especially given the fact that this group of patients can be in hospital for fairly lengthy periods of rehabilitation.

Recommendation 4:

Managers should plan to provide single room accommodation to ensure maximum benefit to patients.

Summary of recommendations

1. Managers should review all current T3 certificates ensuring medical staff pursue DMP visits urgently.

2. Managers should put an audit system in place to ensure that all medication prescribed under the mental health act is legally authorised.

3. Managers should ensure that the rehabilitation service receives dedicated TAN provision commensurate with that provided to other wards on the hospital site.

4. Managers should plan to provide single room accommodation to ensure maximum benefit to patients.

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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