Mental Welfare Commission for Scotland

Report on announced visit to: Appin Ward, Stobhill Hospital, Balornock Rd, Glasgow G21 3UW

Date of visit: 2 March 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Appin Ward is a 20-bedded ward providing care for older adults from across Glasgow City who have complex mental health care needs. The ward opened in October 2020, and currently has 11 patients. Recruitment is underway to enable the ward to open to full capacity. All bedrooms have en-suite shower rooms. The ward has a large open plan sitting and dining area which opens onto a courtyard garden. The ward also benefits from an activity room, another small sitting room, a second small courtyard area and an enclosed external garden space as well as a number of sitting areas spaced throughout the building.

Who we met with

We met with and/or reviewed the care and treatment of eight patients and four carers/relatives.

We spoke with the senior charge nurse (SCN) and clinical service manager.

Commission visitors

Margo Fyfe, Senior Manager (Practitioners) West Team

Mary Hattie, Nursing Officer

What people told us and what we found

All of the relatives we spoke with were very positive about the care provided. They spoke of staff being caring, understanding and showing empathy towards both the patients and their families. We heard that relatives felt confident that their loved one was receiving the best possible care. All relatives commented positively on communication and told us that staff are proactive in contacting them if there are any changes or concerns in relation to their relative. We heard that both nursing and medical staff ensure that proxy decision makers are involved in decisions about individuals' care and treatment.

Care, treatment, support and participation

Multidisciplinary Team

There are two consultant psychiatrists attached to the ward and multidisciplinary team (MDT) reviews are held fortnightly for each consultant. There are twice weekly GP visits, and access to medical cover from the hospital duty doctor rota. We were informed of good input from allied health professionals, with dedicated input from psychology, pharmacy, physiotherapy and occupational therapy, and other services such as speech and language therapy and dietetics are readily available on a referral basis.

The majority of patients have an allocated social worker and they are involved in MDT reviews. We heard that the psychology input is a relatively new development and as well as working with individual patients, the psychologist leads a reflective practice group for staff.

Three monthly MDT reviews are held for patients, and named persons and/or carers are invited to attend these since Covid-19 restrictions are easing. MDT decisions were clearly recorded and we found evidence of relatives and/or carers being consulted and informed regarding care decisions.

The ward uses a mixture of electronic and paper records. MDT reviews are recorded on the EMIS electronic record keeping system and we found that MDT decisions were clearly recorded with evidence of consultation with proxy decision makers. However, the recording of attendees at MDT reviews was inconsistent.

Care Plans

Care plans are held in the paper record, with risk assessments, chronological notes and care plan reviews being recorded on EMIS. Within the files we looked at, risk assessments were documented and reviewed regularly. The level of detail contained in the care plans varied, with some very detailed and some requiring further development as they did not fully reflect the person centred work which was being undertaken. Care plans were being reviewed on a regular basis, however the reviews did not provide adequate information about the patient's presentation, effectiveness of intervention and/or progress towards care goals. We found two files where the care plan had not been updated to reflect a change in legal status, despite this being noted in the care plan review.

Care plans for stress and distress, where these were required, varied significantly in quality with some containing detailed information on the behaviours which may occur, possible triggers and a number of management strategies which could be utilised. Others made reference to the need for identifying triggers and strategies, with no detail included despite the patients having been in the ward for several months. We found that physical health needs were being managed well and this was reflected in the care plans

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/node/1203

We look forward to seeing improvement in care plan recording during our next visit.

Recommendation 1:

MDT minutes should include a record of those in attendance.

Recommendation 2:

Managers should audit care plans on a regular basis to ensure the interventions are person centred and care plans are updated following evaluations to reflect any changes in the individuals care needs and legal status.

Recommendation 3:

Care plan reviews should include adequate information on patient presentation, impact of interventions and progress towards the care goal.

Use of mental health and incapacity legislation

Where patients in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') copies of detention paperwork were on file.

Part 16 (ss.235-248) 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 (T3B) under the Mental Health Act were in place where required and covered all prescribed treatment.

Where patients had a proxy decision maker appointed under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'), this was recorded. We found copies of the powers held by the proxy within the files we reviewed.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. We found completed s47 certificates and treatment plans in the notes of the patients we reviewed who lacked capacity. In addition, the proxies we spoke with told us they had been consulted in relation to treatment decisions. However, we found that this had not been recorded on a number of the s47 certificates we reviewed.

Recommendation 4:

Managers should audit s47 certificates to ensure that consultation with proxy decision makers is recorded.

Rights and restrictions

The ward doors are controlled by keypad or push button release. The ward has a locked door policy and has information on how to access/egress the ward displayed beside the doors. Patients who are assessed as safe to leave the ward unescorted are provided with the door code.

We saw advocacy posters and leaflets available in the ward foyer and we spoke to patients who used this service.

Visiting arrangements comply with current government guidance. We heard that all visit requests are accommodated.

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

Activity and occupation

The ward has an activity team comprising a therapeutic activity nurse and nursing assistants. There is also a part time occupational therapist post, however this is currently vacant. We saw evidence of regular activities being undertaken on a one-to-one and small group basis, both during our visit and evidenced within the care files we reviewed. This included taking patients outside for walks and shopping trips. We also heard from relatives that patients were supported by nursing staff to go outside on a regular basis.

In the files we reviewed, the activity care plans were a standardised plan with no person centred information within it. This did not reflect what we heard from patients and relatives about activities. We found in the chronological notes that there was evidence of patients participating in activities appropriate to their preferences and skills. Each patient file contains an activity planner which is compiled weekly by the therapeutic activity nurse in collaboration with the patient.

We were told that there had been limits on the number and types of outings which could be undertaken due to Covid-19 regulations. The ward has access to a minibus and two wheelchair accessible vehicles. We heard from staff that as restrictions ease, there are plans to expand the activity programme to include theatre and cinema trips and other social outings.

Recommendation 5:

Activity care plans should be reviewed to include person-centred information about the individual’s hobbies, skills and interests.

The physical environment

The ward is a new build designed to meet the current safety standards for adult mental health units, and furniture and fittings are designed to reduce ligature risks. However, we noted that there may be a potential ligature risk from the safes within the bedrooms. The unit is bright, clean, spacious and pleasantly decorated with art work depicting local places of interest throughout the corridors. There are raised beds and benches in both the courtyards and the external garden area is landscaped with flower beds and garden furniture. There is a laundry facility for patients to use.

Recommendation 6:

Managers should review the positioning of the safes for potential ligature risk.

Summary of recommendations

1. Multidisciplinary team (MDT) minutes should include a record of those in attendance.

2. Managers should audit care plans on a regular basis to ensure the interventions are person centred and care plans are updated following evaluations to reflect any changes in the individuals care needs and legal status.

3. Care plan reviews should include adequate information on patient presentation, impact of interventions and progress towards the care goal.

4. Managers should audit S47 certificates to ensure that consultation with proxy decision makers is recorded.

5. Activity care plans should be reviewed to include person-centred information about the individual's hobbies, skills and interests.

6. Managers should review the positioning of the safes for potential ligature risk.

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.

Suzanne McGuinness
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 Commission 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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