Mental Welfare Commission for Scotland

Report on announced visit to: Stobhill Hospital, Armadale Ward 133 Balornock Road, Glasgow G21 3UW

Date of visit: 1 June 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.

Armadale Ward is a 20 bed adult acute admissions ward. The ward is based in McKinnon House on the Stobhill mental health campus. 16 of the beds are for adult acute admissions and four beds are dedicated to the eating disorder service. We previously visited this service on 29 May 2019; there were no recommendations from this visit. Armadale Ward has six single rooms, only one has en-suite facilities, there are other rooms which are dormitory style with a toilet/shower area in them. On the day of our visit the ward was at capacity with all 20 beds occupied.

Due to Covid-19, there has been a change to the admissions process from previous visits. All new admissions go to Elgin Ward where they are assessed, have a period of isolation (as per government guidance) and post isolation they are moved to their locality ward. Armadale ward covers the locality area for North Glasgow and East Dunbartonshire.

Who we met with

We met with and reviewed the care and treatment of six patients, four of whom we met in person and reviewed the care notes of two others. We also met with the relative of one of the patients.

We spoke with the senior charge nurse (via Teams on 31 May 2022), the charge nurse (CN) on duty and the consultant for the eating disorder service. We spoke with the therapeutic activity nurse (TAN) and we also met with hospital managers.

Commission visitors

Anne Craig, Social Work Officer

Mary Leroy, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

It was clear there was a multi-disciplinary approach to the care of the patients on the ward. There are seven consultant psychiatrists providing clinical input to the patients in Armadale ward. As an acute admissions ward there was a mix of patients ranging from those who were acutely unwell to those patients who were preparing for discharge; there were two patients who were on pass. On the day of our visit there were five patients on enhanced observations, this is a significant number of patients requiring additional support. This does impact on staffing but we observed a good ratio of staff to patients and the ward, although busy was calm. We also witnessed unobtrusive observation of all patients on the ward. The atmosphere in the ward was welcoming and we observed that staff engaged well with patients and Commission visitors.

Most of the patients we spoke to praised the nursing staff, noting that they were caring, sensitive and spent time with the patients, which was viewed by them as important. One patient advised she felt "cared for, staff heard what she had to say and she felt listened to." Other comments were that staff were helpful and calming. Patients viewed their relationship with staff as key to their recovery and their interaction with the therapeutic activity nurse as crucial to their wellbeing.

We spoke with one carer on our visit. We heard from the patients that their carers and extended family have input into their care. If issues are identified to the multidisciplinary team they actively work to address any concerns raised by patients and their carers.

Care records

There is an ongoing phased transition from paper notes to EMIS Web. We were assisted to view care plans which were mostly person-centred and there was evidence of patients having one-to-one time with their named nurse. The admission care plans (paper-based) appeared, on reading, as generic, but care plan recording on EMIS Web was more robust and detailed. On EMIS Web there was evidence of ongoing review and person-centred planning was clearly demonstrated. Care plans for patients in the eating disorder service were noted to be of a higher standard and more detailed.

Risk assessments were good, regularly reviewed, updated, appropriate and person centred.

We found that the patient daily nursing notes were excellent.

We would expect that once the transition to electronic recording is complete that there will be whole system holistic recording of the patient's journey.

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

Multidisciplinary team (MDT)

MDT meetings are held at the start of each week. There are seven medical staff who cover the patients on the ward and we heard that patients are reviewed by their consultant psychiatrist who works from the admissions unit, (Elgin Ward) sometimes using TEAMS. This seems less person-centred although we were advised that following the MDT meeting, the consultant visits the patient in-person to discuss their care. Relatives are invited to attend MDT meetings as appropriate and invites can come from the patient or from the multi-disciplinary team. We saw evidence of MDT decision making in the patient notes on EMIS Web. Actions, interventions and the person responsible was also recorded. MDT notes (pre-MDT) demonstrated a good knowledge of the patient and the MDT minutes, care plans and reviews provided an excellent, thoughtful, meaningful review. It was not clear in all cases who was in attendance at the MDT. We would like to see note of attendance at MDT review as a standard item when we next visit.

Use of mental health and incapacity legislation

15 patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act') and five patients were being cared for informally.

Part 16 (S235-248) of the Mental Health Act sets out the conditions under which treatment may be given to those patients who are subject to compulsory measures, who are either capable or incapable of consenting to specific treatments. We reviewed the medication prescription forms and the T2 and T3 certificates. T2 certificates are completed when a patient has capacity and can consent to treatment, T3 certificates are completed when a patient is unable to consent to treatment. There were no issues relating to this documentation.

We noted a section 47 certificate, under the Adults with Incapacity (Scotland) Act 200 (AWI) was completed for one patient which was not renewed on expiry. Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of AWI must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. Section 47 certificates should be reviewed after a period of 3 years.

Recommendation 1:
Managers should ensure that section 47 treatment plans are completed, available and correctly filed in accordance with the AWI Code of Practice (3rd edition).

Rights and Restrictions

The ward door is locked and entry is via a buzzer or keypad. There is a locked door policy and information on this is provided to families and other visitors. Although restrictions due to Covid-19 are reducing, we note that visiting remains limited. The ward provides visiting for 45 minutes per day, managed by a booking system (an hour between each visitor to allow for a 15 minute clean down). Visits take place in the interview rooms or in the patient's room if requested and appropriate.

The ward only has one dining area, meal times are considered as protected time, therefore no visitors are allowed to join patients within the dining area at meal times. Where any patient

may benefit from having family participate at meal times this can be facilitated within the therapeutic kitchen area with the support of staff.

There were three specified patients on the ward during our visit. We reviewed the paperwork in relation to the patients and all was in order.

Our specified persons good practice guidance is available on our website: https://www.mwcscot.org.uk/node/512

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 benefits from a therapeutic activity nurse (TAN), a dedicated activity room and a programme of activities are available for patients during the day. This service would normally run over seven days, however, the current post holder is contracted to 22.5 hours a week; additional staffing for this services are currently being recruited. We observed patients playing a board game and also engaging in making some of the arts and crafts in the main room.

A meeting takes place on a Monday and a plan is created for the week. Patients are central to this plan and the development of a range of activities are offered, such as relaxation, arts & crafts, pampering and there is a gardening group that has been growing potatoes and tomatoes. Bingo and board games are also popular. There is a music volunteer, and it is hoped that in the near future, increased voluntary support for activities will increase. There is a volunteer co-ordinator who supports and manages the volunteer service.

Most patients spoke positively about the range of activities available to them and we noted the activity programme displayed on a board in the dining room. We were told that as yet, the wards are unable to have patients meeting up to undertake activities, however recently the ability to share activities between wards has taken place.

Recommendation 2:
Managers should ensure that when a patient accepts or declines activities offered this is noted in the patient's file.

Physical Environment

Armadale Ward shares a communal entry area with three other wards. The accommodation was built around 2000. The design of the wards is of an older style and would benefit from maintenance and upgrade. The ward is clean, light and spacious and there were several rooms which are used for smaller groups as well as a larger living area which led out on to the garden. During our visit there were several patients who were watching television, there were a few staff sitting with the patients enjoying general conversation and providing support as needed. We noted that storage of patients' personal belongings was an issue; these concerns were shared with the hospital managers and although they were aware of some of them it is necessary that in respect of basic hygiene and health and safety these are prioritised with maintenance services.

There is an adjacent garden area where patients can spend time, which is in need to some basic maintenance. We did witness patients using this area but mainly as a smoking area, although patients who did not smoke did not actually highlighted this as an issue. This area is an enclosed space with fencing for privacy from the main road and the adjacent ward. We were assured that maintenance have been contacted and a programme of grass cutting and ward maintenance is in place.

Recommendation 3:
Managers should ensure that a system is in place to ensure maintenance requests are responded to in a reasonable time frame.

Recommendation 4:
Managers should ensure that the garden area is maintained to provide a safe, pleasant and easily accessible area for patients and visitors.

Other comments

We asked that some consideration is given to the eating disorder service having their own dedicated staff team and not being co-located in an acute admissions ward. We are assured by the hospital managers and with our conversation with the eating disorder service consultant psychiatrist that this is being considered, particularly as there are disproportionately fewer beds in relation to the population that the service covers.

Summary of recommendations

1. Managers should ensure that section 47 treatment plans are completed, available and correctly filed in accordance with the AWI Code of Practice (3rd edition).

2. Managers should ensure that when a patient accepts or declines activities offered this is noted in the patient's file.

3. Managers should ensure that a system is in place to ensure maintenance requests are responded to within a reasonable timeframe.

4. Managers should ensure that the garden area is maintained to provide a safe, pleasant and easily accessible area for patients and visitors.

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.

Claire Lamza
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 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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