Mental Welfare Commission for Scotland

Report on announced visit to:

Broadford Ward (previously Nairn Ward), Stobhill Hospital, 133 Balornock Road, Glasgow G21 3UW

Date of visit: 3 August 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.

Broadford Ward is a 20-bedded unit divided into three areas. The unit provides assessment and treatment for adults who have a diagnosis of mental illness and is also an ESTEEM ward, providing assessment and treatment for first presentation psychosis. On the day of our visit there were no vacant beds.

We last visited this service on 17 September, 2019 and made recommendations on the patient transfer model taking into account the views of patients, staff and carers. The service responded by providing an action plan that gave details on planned specific consultations with stakeholders.

On the day of this visit we wanted to follow up on the previous recommendation and to hear how patients and staff have managed throughout the pandemic. We were told that staffing was exceptionally difficult at times, mainly due to vacancies and annual leave. However, comments we heard about staff were that they were “exceptional” and “stepped up” to ensure there was no detriment to their patients or to the service. It was recognised that staff wellbeing was crucial during the pandemic and a 20 minute “care space” for staff with psychology colleagues was made available to all staff. This arrangement will continue as staff felt it was and still is a valuable resource.

We also wanted to find out if there had been progress made towards reviewing the patient transfer model. However, in response to the effects of the pandemic the admission process was changed to allow for the requirement for patients to isolate for the initial in-patient period. The change included initial admission to the admissions hub (Elgin ward) and subsequent transfer, post isolation, to the home ward.

Who we met with

We met with, and reviewed the care of eight patients, six of whom we met with in person and tow for whom we reviewed the care notes of. We also met with one relative.

We spoke with the senior charge nurse and the clinical nurse manager.

Commission visitors

Anne Craig, social work officer

Mary Hattie, nursing officer

What people told us and what we found

Care, treatment, support and participation

All patients and relatives we spoke with were very positive about the care and treatment they and their relatives received on the unit. Patients said they felt safe and cared for, with one patient commenting that when there was a certain team on shift led by the Senior Charge Nurse she felt "very safe". Another patient commented that the whole staff team were "wonderful", believing that her recovery has been directly attributable to the consultant and the nursing team on the unit. Throughout the visit we saw kind and caring interactions between staff and patients. Staff that we spoke with knew the patients well. It was good to note that patients we met were genuine in their praise for staff

There was specific reference to the therapeutic input by the therapeutic activity nurse (TAN) who has recently moved to another post and the patients were feeling the loss of this role, but they commented that the staff team were trying to provide activity and support normally undertaken by the TAN until a new appointment can be made.

When we last visited the service we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. On this visit, when we reviewed the care plans, we were pleased to find that there continues to be good examples of person-centred care plans that evidenced patient involvement, which had meaningful, regular reviews. Risk assessments were appropriate and up to date. We were also pleased to see that discharge care plans were in place, where appropriate. We also found comprehensive information contained in patients' one-to-one discussions with their named nurse, that was recorded electronically and in the daily notes.

We saw that physical health care needs were being addressed and followed up appropriately by referral and provision of other health services as required.

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)

The unit has a multidisciplinary team (MDT) on site consisting of nursing staff, psychiatrists, occupational therapy staff, speech and language therapy staff and psychology staff. Referrals can be made to all other services as and when required. Referrals for allied health professional (AHPs) input can now be made on EMIS, the electronic records system, and would usually follow on from discussions at an MDT meetings. We heard that meetings had been held online during the restrictions and that this had enabled more professionals to attend. It was acknowledged that by continuing to hold these meetings in this way enhances the flexibility of attendance and interaction. With more face-to-face MDT's over future months, it is hoped that this will also increase patient attendance and participation.

The ward has a broad range of disciplines either based there or accessible to patients. It was clear from the detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to attend the meetings and give an update on their views. This also includes the patient and their families should they wish to attend. It was clear to see from the notes that when the patient is moving towards discharge that community services also attend the meetings.

Care records

Information on patients' care and treatment is held in two ways; there is a paper file and the electronic record system, EMIS. We found that both formats complemented each other and information was easily accessible on both paper and EMIS. There are plans for all information to be uploaded to EMIS and this is in progress. All risk assessments were on EMIS and were easily found, as were the daily notes and the MDT records. Information on a patient's status was easily identified on EMIS and information on their time out status was on the paper records for easy access. The hospital will soon transfer to HEPMA, the electronic medication prescribing record.

Use of mental health and incapacity legislation

On the day of our visit, 15 of the 20 patients in the unit were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The patients we met with during our visit had a good understanding of their detained status, where they were subject to detention under the Mental Health Act.

All documentation pertaining to the Mental Health Act and Adults with Incapacity (Scotland) Act 200 (AWIA), including certificates around capacity to consent to treatment, were in place in the paper files and on EMIS and they were up-to-date.

Part 16 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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed. We found that T3s had been completed by the responsible medical officer to record non-consent; there was one T3 that required updating. We discussed this with managers on the day and the senior charge nurse agreed to discuss with medical staff to have this updated immediately.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

If there was a guardianship order under the Adults with Incapacity (Scotland) Act 200 (AWI Act) they also knew what this meant for them.

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. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. On the day of our visit we found that for one

patient, a s47 certificate was required, although there was a proxy decision maker in place. We discussed this with managers on the day; they agreed the patient should have a s47 and advised us that they would attend to this immediately.

Rights and restrictions

Broadford ward continues to operate a locked door, commensurate with the level of risk identified in the patient group. The unit 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 found that visiting remains limited. The unit 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 the MDT room if it is free, or in the patient's room if requested and appropriate. Visitors and patients can also go out into the grounds for a walk if appropriate.

Where there were patients who could go out of the unit on pass, this was clearly documented, with risk assessments completed appropriately, and action plans to be followed if the patient did not return at the specified time.

There were no specified patients on the unit during our visit.

Our specified persons good practice guidance is available on our website at:
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.

During our visit there were three patients on continuous interventions, under the guidance published by Health Improvement Scotland (HIS). The guidance *From Observation to Intervention* (HIS, 2019) provides a proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care.

The three patients had been assessed as requiring increased care levels due to concerns that they may self-harm or were acutely unwell. The HIS guidance can be found at: https://ihub.scot/media/5508/spsp-iop-from-observation-to-intervention.pdf.

When we are reviewing patient files we looked for copies of advanced statements. The term 'advanced statement' refers to written statements made under ss274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit we found that where advance statements had been made this was noted on the paper file and on EMIS.

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

We are aware that during the pandemic restrictions put in place had meant that various activities out with the unit had to be put on hold. As highlighted earlier, although the TAN post has recently become vacant, a new appointment has been made to the post and is currently subject to the usual checks prior to commencement of employment. We look forward to seeing how this has progressed when we next visit.

At the time of our visit it is not yet possible for patients in Broadford to mix indoors with patient from other units; they can only do this outside at present but it does give opportunity for walking groups in the nearby park or outside activities to be undertaken, subject to the usual risk assessments.

Now that restrictions are beginning to lift and patients are once able to resume some community activities, they are having to adapt and cope with the changes this brings. We heard that staff have gone the extra mile to facilitate activity and ensure patients' needs in this area are met. All patients and relatives we spoke to praised all the staff in their efforts to support the patients in re-adjustment post Covid-19.

The physical environment

The layout of the unit consists of six single rooms all with en-suite facilities, two four-bed dormitories and one six-bed dormitory. Each dormitory has its own shower room and toilet. The unit has a large day room, with access to an enclosed garden and a smaller quiet room. There is a bright, airy dining room with a view of the garden. There are roof skylights in the main corridor which add to the sense of space and light. Decoration was good and throughout the unit there were several pictures by a local artist which gave the unit a homely feel.

We heard how access to the garden from the unit really helped patients with their wellbeing.

Any other comments

In the past we had been concerned about patients being on the unit for extended periods of time as delayed discharges. We were pleased to hear that at the time of our visit there was one patient who was delayed, awaiting a service being put in place. The discharge co-ordinator is actively working with the local HSCP to promote early discharge for this patient.

Service response to recommendations

The Commission made no recommendations, therefore no response is required.

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.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk